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ABSTRACT

This project demonstrates the feasibility of adding preventive and rehabilitative services to a mental health program for the deaf in order to improve program effectiveness. Rehabilitation services for inpatients begin when the patient enters the hospital. Social workers and rehabilitation counselors work with family and community agencies to pave the way for social and vocational acceptance of the deaf patients. Halfway house facilities and close liaison with state vocational rehabilitation counselors are used to ensure smooth adjustment after discharge, with similar facilities available to clinic patients. On the preventive level, consulting services at a school for the deaf are supplemented by group therapy, group counseling for parents, and discussions with teachers and cottage personnel. The program's success is measured not only by the number of potentially chronic hospital inmates who are rehabilitated, but also by the increased community cooperation and awareness of mental health needs of the deaf. (Author)

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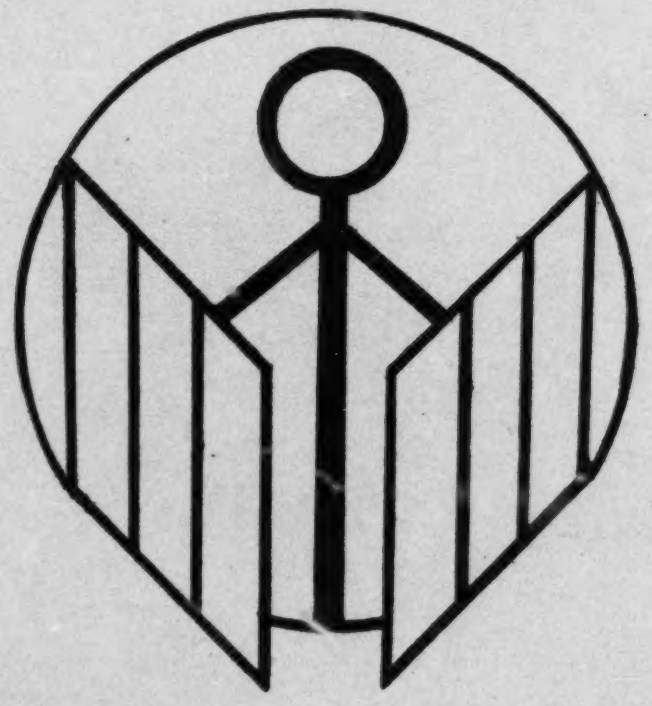
EXPANDED MENTAL HEALTH CARE FOR THE DEAF: REHABILITATION AND PREVENTION

John D. Rainer, M.D. and Kenneth Z. Altshuler, M.D.



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Research Foundation for Mental Hygiene, Inc.

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SIGNIFICANT FINDINGS FOR REHABILITATION AND SOCIAL SERVICE WORKERS

This report describes rehabilitative and preventive services for the deaf functioning in a psychiatric setting. While New York State has maintained a comprehensive psychiatric program for the deaf since 1966, based on the results of previous demonstration projects, most areas of the country will have to organize the basic outpatient and inpatient services as well. Therefore the following statements incorporate the findings and recommendations of the earlier projects also.

1. Mental illness and emotional difficulty are no less prevalent among the deaf than among the hearing. Diagnosis and treatment are more difficult and take longer.

2. Experienced mental health personnel (psychiatrist, psychologist, social worker, rehabilitation counselor, nurse) must and can be recruited and trained in manual communication and special problems of the deaf. A teacher of sign language is an early and prime requisite.

3. Psychiatric treatment methods (individual and group psychotherapy and pharmacotherapy) can be adapted and applied to the deaf patient.

4. A clinic can be established once the personnel are available and will draw referrals from schools, rehabilitation agencies, families, physicians and the deaf themselves.

5. The deaf community can be made aware of the value of mental health facilities and will give aid by educational and volunteer programs, once the stigma of mental illness is removed.

6. For the acute or more seriously mentally ill deaf person, inpatient

hospital facilities are the most efficient means for concentrating therapeutic efforts. A ward for patients of both sexes, with a specially trained staff is most effective, and 30 beds has been found adequate to deal with the needs of the adult deaf population of a state as large as New York. Patients with illness of recent onset have the best prognosis, but chronic patients transferred from other hospitals to such a special ward often do strikingly well.

7. Such a ward ought to offer as a minimum medical and nursing care, individual and group psychotherapy, drug and other somatic treatments and an occupational therapy workshop. Group therapy is particularly effective in fostering deaf patients' insight into their own behavior.

8. For the most effective results of a comprehensive treatment program, it has to be supplemented by a rehabilitation approach as described in the present report. Psychiatric case finding, diagnosis, and treatment of the deaf patient only bear full results when a rehabilitation team paves the way back to the outside world. This is especially important for the deaf where many needed facilities must be built or strengthened.

9. The rehabilitation counselor can function best as part of the mental health team, working in regular liaison with state agencies to open case files while patients are still under treatment. Exploration of patients' vocational skills and interests must begin before discharge and the lag between discharge and placement kept at a minimum.

10. Through occupational therapy workshop and other vocational training shops, new skills can be developed. Group and individual teaching in the hospital can improve patients' abilities in the 3 R's; for this an experienced

teacher for the deaf is essential.

11. Housing is of prime importance; by adding an experienced social worker who knows the problems of the deaf and can communicate well, it is possible to arrange for such placement (family, individual, home, foster care, as the case may be), and to teach the patients how to go to and from work and organize their lives in the most healthy way.

12. Halfway house facilities in the community can be used for interim housing and reintegration of the deaf hospital patient into the community. A social worker at the halfway house specially assigned to the group of deaf persons can effectively show them the upward path of increasing independence. Deaf and hearing ex-patients work together well at this halfway house level.

13. Turning to prevention of psychiatric disturbance, schools for the deaf can make effective use of a mental health team--psychiatrist, psychologist and social worker. Trouble shooting with early psychiatric intervention is but one approach. Group therapy with adolescent students encourages greater awareness of interpersonal relations and forestalls problems in this area. Discussions with teacher and cottage personnel alert them to difficulties and assist them in proper handling of their pupils.

14. Since mental health begins at home, early contact with parents of deaf children and counseling, individually and in groups, can help these parents to overcome their guilt and shame, avoid the extremes of overprotection and rejection, and encourage them to communicate with the children by all means available. Social worker and psychiatrist can both work in bringing parents together for this purpose.

15. Deaf professional personnel can be of great value at all levels and should be recruited or trained whenever possible.

ABSTRACT

The project described in the current report which ran from 1966 to 1969 demonstrates the feasibility of adding preventive and rehabilitative services to a mental health program for the deaf so as to increase the effectiveness of the entire program.

In providing psychiatric services for the deaf in New York State, the Department of Mental Hygiene, represented by the New York State Psychiatric Institute and Rockland State Hospital, had by 1966 established comprehensive inpatient and outpatient units for treatment. Under the expanded organization represented by this new project, rehabilitation services for inpatients begin when the patient enters the hospital. Social worker and rehabilitation counselor work with family and community agencies to pave the way for social and vocational acceptance of the deaf patient. Halfway house facilities are tested while the patient is still in the hospital and are used after discharge as a bridge to the community. Close liaison with state vocational rehabilitation counselors ensures smooth transfer to employment status. Similar facilities are available to clinic patients.

On the preventive level, consulting services at a school for the deaf are supplemented by group therapy for students, group counseling for parents, and discussions with teachers and cottage personnel.

The program's success is measured not only by the number of patients rehabilitated who otherwise would have become chronic hospital inmates, but also by the degree of community cooperation elicited and the increasing awareness of mental health needs of the deaf throughout the country.

PREFACE

This report deals with the third of New York State's consecutive projects directed towards better mental health services for its deaf citizens. The programs from the beginning have been sparked by a notable sense of dedication and spirit of team endeavor. A sense of teamwork also perfused the present project and has been equally in evidence in the preparation of this final report. Several individuals contributed material for each chapter as the data were gathered together and revised and then ground through the final editorial mill. The editors of course have the final responsibility for what is contained herein, but we would like to acknowledge particularly the contributions of Drs. Syed Abdullah and W. Edwards Deming to the section on the hospital population and results, Mrs. Jean Badanes, with the help of Dr. John Vollenweider and Mr. Steven Chough in the rehabilitation procedures section, Dr. Georgina Macario in the part on inpatient procedures, and Dr. M. Bruce Sarlin throughout the section on the preventive program. Dr. Deming was invaluable in his early design of data collection systems as well as in the compilation of final figures. While these individuals warrant special mention for their help with words, the entire staff deserves a full measure of credit for their deeds, their steadfastness and unstinting willingness to work.

We should also like to thank particularly Miss Mary Switzer, Commissioner of the Social and Rehabilitation Service for her consistent interest in our investigations, and Dr. Boyce Williams, Chief of the Communications Disorder Branch of the Social and Rehabilitation Service, for his guidance, support and special readiness at any instant to expedite the movement of our work. Dr. L. Deno Reed, Chief of the Sensory

Study Section, Division of Grants and Demonstrations, gave us considerable procedural guidance and deserves credit for helping us to wend our way through the maze of applications, contracts and other papers without losing both bearings and effectiveness. Dr. Roy M. Stelle, Superintendent of the New York School for the Deaf and his staff participated with enthusiasm and understanding in the school program; Mr. John H. Beard as Executive Director of Fountain House was quick to see the potential in halfway house living for deaf patients and to respond with genuine spirit. Miss Mima Cataldo worked without complaint for long hours over mangled manuscripts, and in warm library stacks and cold office files; her efforts, along with those of Mrs. Donna Szumski in the actual manuscript preparation, are also gratefully acknowledged.

Most of all we would like to note our debt to the deaf community of the State of New York. From the faintly apathetic reception first accorded us 15 years ago, they have gradually come to take an increasingly proud and active interest in our work. They have asked for and learned from our speakers and made increasing and appropriate use of the services developed. They have supplied not only the patients to be aided but voluntary groups to lend aid as well, and an ever growing, gratifying awareness that mental health and its maintenance are valuable commodities.

John D. Rainer M.D.

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THE BACKGROUND OF THE PROJECT AND ITS AIMS

Introduction

In a brief span of only 15 years, from 1955 to 1970, psychiatric services for the deaf in New York State developed at an almost incredible rate. Germination led to action and fruition, and where there was nothing, there now stand an outpatient unit, an inpatient unit, and a special rehabilitative and preventive program. All of this is devoted to the mental health care of persons with early total deafness and all at this writing are permanent parts of the State's mental hygiene facilities.

The pages that follow will detail the problems and progress of the rehabilitative and preventive parts of the program. To set the findings in their proper context it is necessary to sketch briefly the results of the preceding projects and to define situations that the present study was designed to meet.

The first of New York's projects commenced in 1955 and terminated in 1962. It called for a state wide census of the deaf, the gathering of basic statistics, and the establishment of normative data by means of a large scale interview covering areas of basic life experience in some 300 randomly selected deaf persons and families. It further sought to define the impact of deafness by gathering for special study all deaf twins east of the Mississippi and similarly surveying other special groups such as deaf criminals or persons of unusual achievement.

All of this was the backdrop to the essential thrust of that study, the investigation and definition of mental health problems in the deaf and an effort to bring modern psychiatric techniques to bear in their treatment. The project therefore opened the country's first psychiatric outpatient clinic for the deaf, and located, documented,

and followed all deaf patients in the State's 21 far flung mental hospitals.

The experiences of those 7 years indicated that psychiatric diagnosis and therapy could be applied to the deaf provided well-trained professionals took the time to grapple with the many special problems that were met. Though the communication barrier posed formidable obstacles, these could be surmounted with a working knowledge of manual language and unusual amounts of time and patience.[1] The outpatient clinic functioned with surprising effectiveness, serving more than 200 patients despite the fact that it operated only 2 days a week and was little publicized. But inpatients, numbering some 250 at a given time, were able to receive relatively little help. Scattered throughout the state and generally having reduced or altered communication skills, these patients were often found to be isolated, wearing inaccurate diagnostic tags, poorly evaluated, and virtually untreated. Our staff visits rectified diagnostic errors and provided some follow up, but could hardly afford the consistent and continuous care necessary for recovery to be encouraged and sustained.

The second project, demonstrating comprehensive mental health services for the deaf, ran from 1963 to 1966 and was designed to remedy this limitation. While it expanded the outpatient clinic, its primary contribution was the demonstration of a special inpatient unit for the deaf. This special facility, the first of its kind, housed 30 inpatients, 15 males and 15 females, and provided a staff that was professionally skilled and conversant with manual language to define and meet individual treatment needs

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[1] The results are reported in detail in the monograph "Family and Mental Health Problems in a Deaf Population". Rainer, J.D., Altshuler, K.Z., and Kallmann, F.J. (eds), New York State Psychiatric Institute, New York, 1963; Second edition, Charles C. Thomas, Springfield Illinois, 1969.

with flexibility and dispatch.

The unit was located in a specially altered section of Rockland State Hospital, about 20 miles from New York City. Its mission was that of an intensive treatment unit, and this fact—plus the problems related to the added handicap of deafness—required a heavy staff-to-patient ratio (see pp.17-20). During the first 3 years of its operation, the shake down cruise and test run, some 50 patients were treated. The first patients were transferred from other State hospitals; as procedures for handling various eventualities were worked out and the unit came to function smoothly, acute cases from the community were accepted; and finally, toward the end of the initial period, arrangements were made whereby chronic cases could be rotated from other State hospitals for a trial of treatment, whenever a space became available, and returned when they had achieved the maximum benefit or were no longer improving.

Of the 50 patients, 22 were discharged and there were only 2 readmissions. Ten of 18 patients entering the unit after 5 years of hospitalization elsewhere were discharged before the first 3 years were out—some after more than 20 continuous years as patients. Because of certain selective factors and the brief period of operation, the limits of our results were difficult to evaluate.[2] Despite the fact that they obviously compared well with those of any intensive care unit for the hearing, we had encountered a number of bottlenecks and felt still further advances were possible.

Meanwhile the outpatient clinic had also continued to function. Ninety-six

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[2] For a full discussion of the inpatient and outpatient results, the rationale and experiences of this project, see Rainer, J.D. and Altshuler, K.Z. Comprehensive Mental Health Services for the Deaf, New York State Psychiatric Institute, New York, 1966.

new patients were evaluated or treated for a total of 1224 visits and the clinic provided continued treatment for patients discharged from the hospital, and for others whose course of therapy had not been complete at the close of the first project. A significant proportion of these clinic patients were deaf adolescents, either students or youngsters dropped from school because of the unmanageable nature of their disturbances in personality.

Our staff also undertook consultative work with a nearby school for the deaf[3] and developed a close working relationship with them. These arrangements gave further ample opportunity to observe the nature of emotional problems to be faced by teachers and school administrators in their efforts to educate and prepare deaf youngsters for productive adult life. The difficulties, and the fact that these efforts often fail in the face of psychiatric problems of the deaf student were attested to by many records in our clinic files.

Rehabilitative and Preventive Psychiatric Programs for the Deaf

The persistent bottlenecks in the inpatient program and our growing awareness of preventable difficulties in childhood and adolescence were twin spurs for initiating the third project—the subject matter of the present report—comprising the rehabilitative and preventive psychiatric programs for the deaf. Our experience had been that the step from hospital to community was an enormous one, most difficult to make for many of our patients. The fact, as in the old joke, that "the first step is the hardest" was compounded for these individuals by the absence of community agencies to

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[3] The New York School for the Deaf, White Plains, N.Y., Roy M. Stelle, Superintendent.

shelter and receive them when they were ready for discharge. Great delays were occasioned in some cases while workers vainly sought homes that could provide adequate placement and supervision of the patient as he struggled to adjust outside the structure of hospital life. Often placement which seemed opportune would shortly prove inadequate, and patients optimally prepared for community living would have to be returned to the hospital. Such disappointments and disruptions could precipitate exacerbations of illness and undo months of careful work. Similar situations obtained in regard to job placement and coordinated entrance into retraining programs, both for in- and outpatients. The first aims of the new project therefore, were to design and demonstrate a program for reintegration of deaf psychiatric patients into the community. This aspect of the project was to emphasize the development of a special halfway house and day care program for the deaf, and the achievement of effective integration between the total psychiatric program and the State rehabilitation agencies and therefore with a variety of training programs. At the same time it would expand our existing services to enable close follow up and supervision of the family and community—as well as the vocational—adjustment of the ex-hospital patient.

The second prong of the project was to design and apply a pilot program of preventive psychiatry for the deaf community in the New York metropolitan area. Primarily child directed, it would function with the cooperation of a local school for the deaf to provide early diagnosis, to conduct indoctrination conferences and training of teachers and cottage parents, and to demonstrate preventive group therapy techniques with adolescents of both sexes and group techniques of guidance for parents of students. Work in the preventive area for adult deaf persons was to be done through education

of the deaf community and of agencies working with the deaf with respect to principles of mental health, early detection of illness and effective cooperation with health facilities.

The underpinnings for this aspect of the work were the facts that while neurotic disturbances of character and adjustment have their roots in early experience, it is the school years that generally offer the first opportunity for persons outside of the family to observe, or ameliorate any manifestations of incipient disorder. Even in our initial study it had been noted that deaf criminals and offenders consistently showed a history of behavior difficulties while in school, and throughout our work, many clinic referrals had been from schools, for sexual problems, stealing, and other symptoms of disturbed personality. The closer working relationship with one school undertaken in the latter part of the second project demonstrated a large unmet need for individual and group counseling among the deaf, and for assistance in the development of concepts of responsibility and feelings of concern for others. There was also a need for providing psychiatric guidance to teachers, cottage parents, and other staff to assist them in encouraging healthy identifications, attitudes, and development in their charges. The lack of guidance for the deaf in problems of marriage and parenthood had also been evident from even our earliest efforts.[4] For example, almost none of the deaf individuals surveyed in interviews of normal deaf persons, and an equally insignificant fraction of those seen in school and clinic, had any meaningful understanding of genetic principles and their consequences for having

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[4] Altshuler, K.Z. and Rainer, J.D. Psychiatric aspects of social and vocational adjustment to total deafness. Am. Ann. Deaf, 103: 317, 1958.

deaf or hearing children. Determination of the most effective ways of providing education in principles of dating behavior, sexual problems and mate choice was clearly a sore necessity.

Of course, both aims of the project would require the continuation of our commitment to recruit and train personnel for work with the deaf, including persons in our particular projects and others, elsewhere in the country, who desired or required such training or who were interested in developing other special psychiatric services for the deaf.

These then were the goals of the present project and its general background. Succeeding chapters will describe the program in operation, the staffing and changes required in previous staffing patterns, and the results and limitations.

Description of Program

As the third phase in the ordered expansion of comprehensive mental health services for the deaf in New York State, the program described in the present report was able to stand upon the shoulders of an already existing operation which provided basic psychiatric care to patients both in the clinic and on the ward. When the inpatient ward was opened at Rockland State Hospital 3 years before, additional members had been added to the staff of the earlier research and demonstration project for the deaf. These persons included a full time supervising psychiatrist, a head nurse and an assistant, a full quota of ward attendants, and a core of specialists experienced in occupational, recreational, and group therapy, psychological examination, and rehabilitation. It was the duty of this staff to admit and arrange for the treatment of severely psychiatrically disturbed deaf patients. Weekly clinical meetings

in the inpatient service were run by the project directors and were devoted to questions of diagnosis, treatment plan, and ward management.

The psychiatric staff as well as the other professional members were also responsible for outpatient services and aftercare treatment of discharged patients. Patients were referred by organizations for the deaf, by the Division of Vocational Rehabilitation, by hospitals and physicians, by correctional and welfare agencies, and by deaf persons themselves.

During that 3 year program some preliminary attempts were made to deal with the preventive and rehabilitative aspects of psychiatric care. These however were largely intramural and of necessity were limited in their extension beyond the walls of the hospital or the clinic. Nevertheless, a ward occupational instructor and a vocational instructor saw to it that patients began to explore avenues of work interest while still under treatment. Two patients were housed on an experimental basis with Fountain House, a halfway house in New York City, but otherwise housing arrangements depended usually upon conferences with families before the patient was discharged. No work was done with children except for consultations at a school for the deaf, but the project directors were well aware of the need for preventive programs of mental hygiene, sex education, and group living among students in schools for the deaf, and also voiced their concern with early parent education as a primary focus for more healthy emotional development in the deaf child.

So it was therefore at the outset of this third phase that the basic area of psychiatric diagnosis and treatment was well explored, its methods were demonstrated, its findings were reported, its program was made permanent, and its staff knew exactly what it wanted to do to fill the unmet needs that had become so obvious.

In setting up the expanded program, search for the proper personnel was all important. The treatment program, a medical program under psychiatric direction, had always had as directors persons who were well trained and experienced psychiatrists versed in psychiatric diagnosis and therapy as well as the special problems of the deaf. The other professional members of the team lent their particular talents to the management of the patients under the care of the project. It was now necessary to supplement the staff by persons who would, in a sense, face both ways—inward toward the core of the program and outward toward the community with its families and institutions that had nurtured and would have to take back deaf persons under the care of the treatment program. The first thing in the development of services was to organize training for the professional persons who would staff a special halfway house and day care program and set up special services for all deaf patients requiring rehabilitation. A full time social worker, trained in the special problems of the deaf and in manual communication, was recruited to deal directly with the families of the patients, the schools, and agencies, the training programs, housing and employment sources and the government and welfare groups needed for the help of our patients. We were fortunate in obtaining for this position the services of a trained social worker, deaf himself, a graduate of Gallaudet College, who was able to take on this job with all the advantages of his first hand knowledge of the problems of the deaf and contacts with the deaf community.

At Fountain House itself, it was necessary to have another social worker assigned to supervise the rehabilitation of the deaf patients under the care of that facility and to help to integrate them with the hearing ex-patients at Fountain House, and with the outside world. One of the skilled social workers attached to that agency was

assigned to this job because she had taken a particular interest in the 2 deaf patients who had gone there on an experimental basis before the project started. During the 3 years of this program this woman served as a liaison between our facility and Fountain House, coming to our staff meetings, discussing the patients before their discharge, and keeping in touch with our social worker and rehabilitation staff regarding their progress at Fountain House.

It had long been our experience that the vocational rehabilitation of psychiatrically disabled deaf persons must be the joint responsibility of the psychiatric team and the rehabilitation counselor once the acute phase of the illness has passed. We therefore added to our group a full-time vocational rehabilitation counselor to work jointly with the psychiatric team, the New York State Division of Vocational Rehabilitation, and other sheltered workshop and training facilities. This person remained with the program for the first 2 years, but then found it necessary to leave. With no replacement found after a good deal of searching, an alternate arrangement was made which worked out equally well. Our part-time rehabilitation counselor who had been responsible primarily for coordinating hospital wide training programs for inpatients increased her amount of time in the program and together with the social worker, organized a regular liaison with the special counselor at New York State DVR assigned to work with the deaf. The state counselor made it a point of visiting our service regularly once each month and was apprised of all new patients as they entered so that plans could be made for their rehabilitation from the very beginning. Many of these patients were actually registered as DVR clients while still in the hospital.

Still in connection with the rehabilitation aspect, an important gap in the preparation of patients for adjustment to the outside world was the lack of education,

particularly in reading, writing, and mathematical skills. This applied particularly to the increasing number of adolescent patients on the ward, but also to a good many of the adults. For that reason a teacher, deaf himself and a Gallaudet graduate, was added to the staff to organize a regular instructional program including testing and retesting of the patients on the ward. This program was conducted on an individual basis and also in small groups.

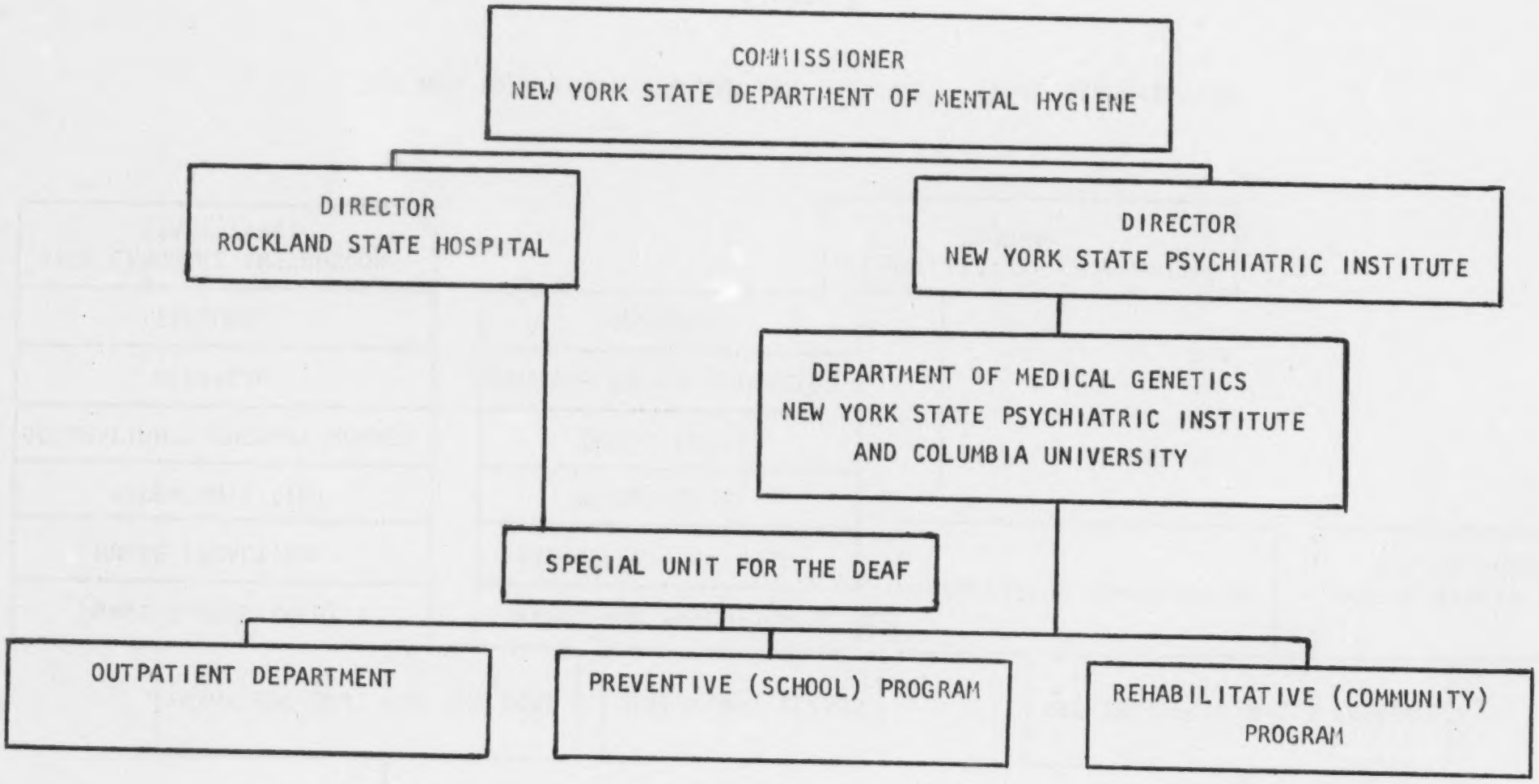
The second major aim of the program was to initiate preventive mental health measures at a school for the deaf which had already pioneered in the use of psychiatric consultants to deal with incipient emotional problems among its pupils. The directors of the present project had for some 3 or 4 years provided weekly consultations at this school. In so doing they worked closely with the mental health team of the school which consisted of a school psychologist and a school social worker. All problem cases were followed through the office of the psychologist and social worker who aided the psychiatrists in their evaluation and in implementing their recommendations. It was now planned however not only to extend psychiatric surveillance to students who had already become problems, but to try to prevent those problems before they arose. This called for a good deal of additional work and for the addition of a psychiatrist who could coordinate this program under the supervision of the project directors. A psychiatrist who had worked with the original demonstration project and who was familiar with the sign language and with the diagnostic problems was reengaged for this purpose. His job was to work together with the existing mental health program at the school, to set up discussion groups among parents of the students to deal with the problems at the home level and the problems dealing with the interaction of parent and child, to set up group therapy sessions with the students

themselves, particularly adolescent students, and to meet with teachers and cottage parents by means of individual conferences and group discussions. The project directors continued to work at the school as well. During the course of the project the use of videotape recording to record group sessions and play them back to the students was initiated.

Such essentially was the new staff which was added for the purpose of the third aspect of the comprehensive mental health program for the deaf. In addition, a research assistant was needed to help coordinate the data obtained in the program, and an instructor in sign language to train all new personnel in manual communication. Of course the existing psychiatric and psychological staff gave part of their weekly time specifically to the new aspects. Figures I and 2 indicate the final structure of the program.

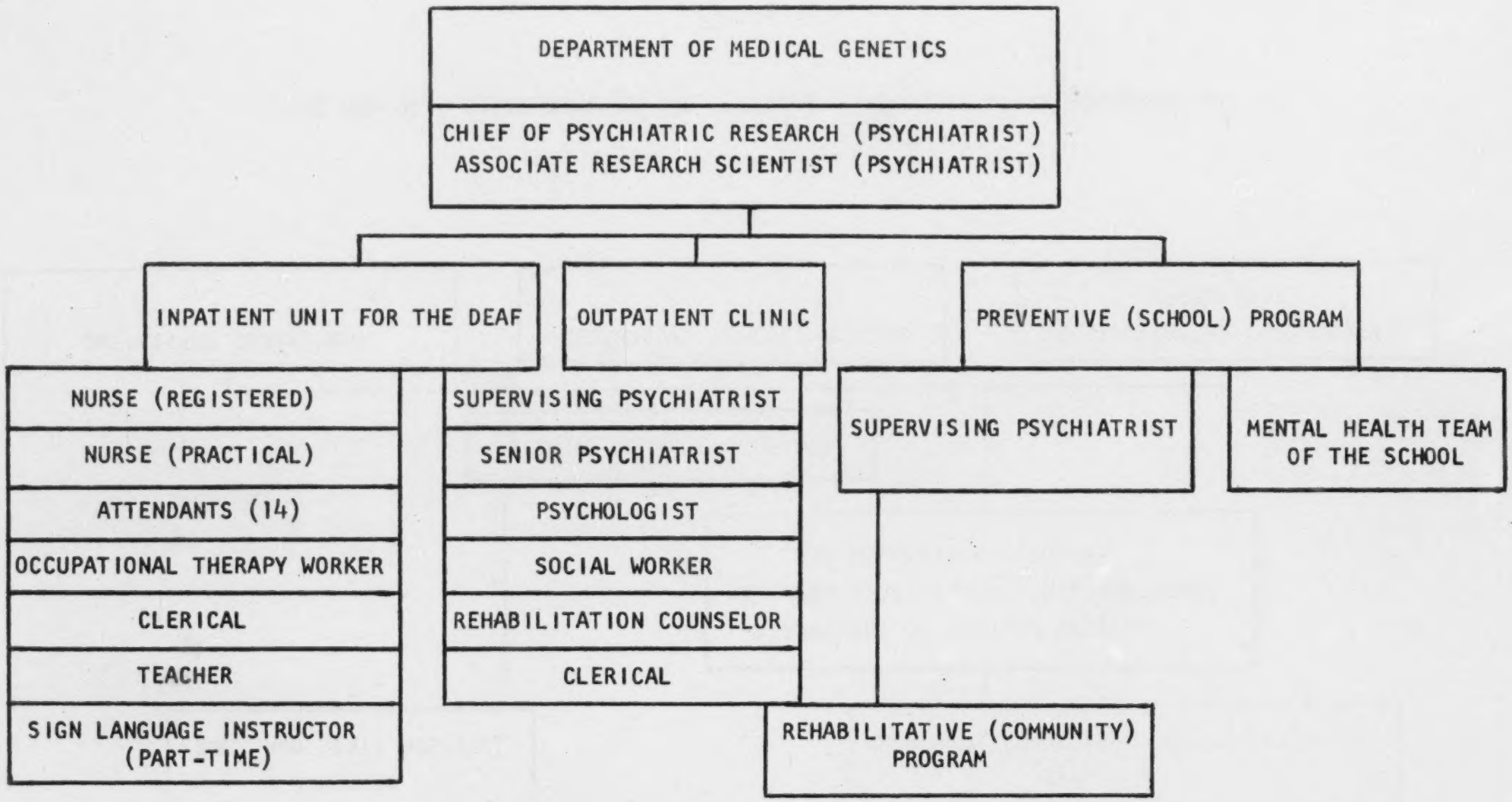
We have said previously that, in the course of the first 2 projects for the deaf, about 5% of the total New York State deaf population had come somehow under our purview, either as patients in hospitals, or as clinic patients. The present program of prevention and rehabilitation added to this list the students at one of the schools for the deaf in the New York City area, the many psychiatric referrals—particularly of adolescents—that came to us through our school affiliation, and the many more referrals from Division of Vocational Rehabilitation that came to us because of our increased channel of communication with them. Several groups of parents, teachers, and cottage parents were added, mostly hearing people but intimately involved in the development of the young deaf individual.

A third goal of the preventive and rehabilitative program was its community aspect. It was planned to organize a series of meetings with deaf leaders, organizations



THE NEW YORK STATE PROGRAM FOR THE DEAF: ADMINISTRATIVE ORGANIZATION

Figure 1



THE NEW YORK STATE PROGRAM FOR THE DEAF: STAFF ORGANIZATION

Figure 2

of the deaf, and the psychiatric community at large so as to bring the entire mental health and rehabilitation program for the deaf once and for all into the common spheres of interests of these groups and make this area a unique and significant one in the mental health field. The most dramatic steps towards these ends were to be 2 major conferences organized by the project directors during the period covered by this project, one for psychiatrists, and a second for non-psychiatric professional workers with the deaf.

In addition, community and educational work was to include participation in national and international conferences, lectures to ministers and other professional and lay groups, and in-service training of Gallaudet summer students, and visiting social workers, psychologists, and psychiatrists from all parts of the world.

THE PROGRAM IN ACTION

Procedures for Inpatients

The special unit for the deaf at Rockland State Hospital is an exception to the rule whereby State Hospitals in New York serve only specifically defined geographic areas. The 20 other far-flung mental hospitals of the State notify the administration of the special unit for the deaf at Rockland when a deaf patient is hospitalized, and any of these patients may qualify for admission by transfer. During the later stages of the project, as policy was solidified, the Department of Mental Hygiene issued a special order which became a permanent part of its Policy Manual and made it possible to transfer to the special ward any patient in a state mental hospital. Equally important, it provided for his return to the original hospital if it were eventually felt that he could neither receive further benefit nor be discharged. In view of the ward's limited capacity, the latter proviso was necessary to avoid eventual crowding with chronic patients.

Periodically, staff of the special unit make trips to the other New York State Hospitals to maintain records on the deaf patients at each, consult with regard to their treatment, and to select for admission mentally ill patients that in their judgment may well benefit from the special unit at Rockland. Referrals also come from community agencies and private individuals who are aware of the special unit. Admission may also be direct, or from city or

county hospitals. Prior evaluation is done on each patient to determine whether he can meet the criteria for treatment on the ward, criteria which include early profound deafness, emotional disturbance, absence of addiction, some possibility of rehabilitation, and age 16 or over. Following the trends of New York State's mental hygiene laws, our patients are admitted on voluntary applications wherever possible.

Upon admission, the patient is assigned to a doctor whose task it is to attend to any immediate needs for treatment, to develop a working rapport with the patient, and to introduce him to the life and routine of the unit. The doctor also begins to gather historical material on the patient's life, illness, and family history, reviews his physical and neurological condition and his deafness, and arranges for administration of psychological tests that are appropriate for the particular case.

Within 2 weeks the patient and all the material gathered are presented at a general staff conference. Here the diagnostic evaluation is considered, along with an estimate of rehabilitation potential; the patient's strengths and weaknesses are reviewed and a plan of treatment is determined.

These weekly conferences also allow for the regular review, whenever necessary or at intervals no longer than 3 months, of each patient's progress, his response to the treatment as outlined, alterations of the program where indicated, post-hospital plans, and any urgent problems that may require attention. Each staff member—psychiatrist, psychologist, O.T. worker, rehabilitation counselor, social worker, teacher and nursing staff—reports his contacts and questions about the patient, and an up-to-date reading is maintained on the pulse of the patient's life. Once every month a large part of the conference is given over to the State's DVR counselor

in charge of deaf patients [5] who reports on the progress of formerly hospitalized patients jointly under her charge and ours and who opens new cases still on the ward so that programs to serve them will be waiting upon discharge. Other designated weeks call especially for reports from the teacher or social worker, from our social worker at Fountain House, and from staff members from other cooperating agencies that are invited to participate as occasion arises.

While on the ward, each patient is exposed to every service offered. Individual therapy is the responsibility of the therapist assigned to the patient on admission. To maintain continuity, the same therapist follows the patient throughout the period of hospitalization and thereafter in the aftercare clinic. Most patients participate in group therapy carried out in sign language and monitored by closed circuit television. The plan allows replay of taped segments of the sessions, affording a feedback for both the therapist and patients. Many pertinent observations come clear through these play-backs, and new, broader awareness of oneself is supported.

Always eager to try new therapeutic techniques, we have had baby chicks on the ward which have been the responsibility of certain patients to feed and to care for, and plants to keep watered, for others. The most recent innovative effort has been a type of reinforcement therapy or behavior-conditioning. Each patient is awarded colored chips according to his behavior in a specific area. After accumulating a specific number of chips, an exchange can be made for certain rewards,

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[5] At the time of this writing, the person in this position is Mrs. Anna Mooney; previously, the slot was filled by Mr. Charles Wilson. Both functioned most diligently to expedite the goals of the project throughout and have lent their full efforts to creating smooth teamwork and effective liaison.

according to the number of chips (candy, movies, and a number of items from a newly established ward store). This method has been especially successful in improving performance in school and in general behavior among the younger patients.

The teacher holds daily classes for the patients and develops individualized programs tailored to a patient's achievements, and ability to concentrate and absorb. Captioned films are utilized for their educational and recreational value, and often serve as taking off points in the group therapy or teaching sessions. The Occupational Therapy (O.T.) program is carried out on the ward by a full-time occupational therapist. Because of the unique situation whereby the O.T. room and teacher's office are situated directly on the ward (the latter with a one-way mirror), observations of the patients can be carried out by all staff members in an unobtrusive manner. Patients are started on these programs as early as their mental condition will permit. The knowledge that is gained through observation of schoolroom behavior and habits in O.T. often has a bearing on rehabilitation plans.

Thus, it can be seen that rehabilitation of the patient is a goal the comprehensive pursuit of which begins in some cases even prior to admission. It is uppermost throughout the period of hospitalization, and after discharge in our aftercare program, where close follow-up constitutes an integral part of the program (cf. The Rehabilitation Program, infra).

The Population

During the 3 years of its demonstration phase, the present project has served a total of 96 inpatients. Of these, 72 were discharged and 24 continued as inpatients at the end of the project period, June 30, 1969. The figures indicate

improvement over the experience of the preceding 3 years, the initial program of special inpatient services for the deaf, when of 50 patients treated, 27 were discharged. The differences reflect the greater efficiency of operation gained with time, perhaps a wider policy of admission, and most important, the impact of the revised rehabilitation aspect of the program with its close DVR liaison and active community extensions.

Tables I and 2 summarize data on a number of important characteristics on both groups as of the end of the project period--patients discharged (72) and patients still on the ward (24). The 2 groups are tabulated separately for ease of reference and discussion. It is doubtful that they represent 2 distinct populations, however, for the composition on the ward is fluid as patients enter and leave, and a number of those still hospitalized at the project's end were improved and awaiting discharge. Indeed, for the most part the figures for both groups are comparable, the only possible difference of note being in the ratio of white to non-white; the non-white comprise 1/3 of those still hospitalized (8 of 24) and only 1/8 of those discharged (9 of 72). It is unclear if this reflects an increasing rate of hospitalization for non-white patients toward the end of the period, or greater difficulty in treatment or placement for the non-white because of more difficult illness, absence of facilities for placement, or other problems.

Interpretation of the tables may enable the reader to gain a sense of the movement and vitality of life and work on the ward. Of the 24 patients on the ward as the project drew to a close, 11 were male and 13 female; nineteen were below the age of 40 and only 5 above, testifying to the youthful nature of our population. Sixteen, i.e. 66%, were diagnosed as schizophrenic, 4 were in the category of behavior

Table 1

Some characteristics of patients on the ward, 30 June 1969

Characteristic		White plus non-white			White		Non-white	
		Male plus female	Male	Female	Male	Female	Male	Female
Age (30 June 1969)	All ages	24	11	13	8	8	3	5
	Under 20	9	4	5	4	3	0	2
	20-29	7	4	3	1	2	3	1
	30-39	3	2	1	2	0	0	1
	40 or over	5	1	4	1	3	0	1
Psychiatric classification	Schizophrenia	16	9	7	6	5	3	2
	Behavior disorder	4	2	2	2	1	0	1
	Other	4	0	4	0	2	0	2
Drugs	Tranquilizer only	17	9	8	7	5	2	3
	Tranquilizer and anti-depressant	3	0	3	0	1	0	2
	None	4	2	2	1	2	1	0
In school on ward	All ages	18	7	10	6	6	1	4
	Under 20	6	4	2	4	0	0	2
	20-29	8	2	6	1	5	1	1
	30-39	2	1	1	1	0	0	1
	40 or over	2	0	2	0	2	0	0
Not in school		6	4	2	2	1	2	1
Is or was in Fountain House		10	2	8	2	4	0	4
Never in Fountain House		14	9	5	6	4	3	1
Was or is in hospital training or industry		9	3	6	3	3	0	3
Never was in hospital training or industry		15	8	7	5	5	3	2

cont'd

Table 1 cont'd

Some characteristics of patients on the ward, 30 June 1969

Characteristic		White plus non-white			White		Non-white	
		Male plus female	Male	Female	Male	Female	Male	Female
Initial prognosis	A	0	0	0	0	0	0	0
	B	8	2	6	2	3	0	3
	C	16	9	7	6	5	3	2
* Deafness in family	Sibling	3	2	1	2	1	0	0
	Parent	1	1	0	1	0	0	0
	Spouse	1	0	1	0	0	0	1
	Child	0	0	0	0	0	0	0
	Other relative	1	0	1	0	1	0	0
	None	17	8	9	5	6	3	3
	Unknown	1	0	1	0	0	0	1
Continuity on the ward	Never discharged	17	8	9	6	7	2	2
	Discharged and re-admitted	7	3	4	2	3	1	1
All patients on ward		24	11	13	8	8	3	5
Months since 1st admission to this ward	36 or more	7	3	4	1	3	1	1
	24-35	3	3	1	2	0	1	0
	12-23	6	2	4	2	1	0	0
	6-11	2	1	1	1	2	0	2
	Under 6	6	3	3	2	2	1	2

* These categories are not mutually exclusive, but it so happens that none of the patients had two of them.

Table 2

Some characteristics of patients discharged

Characteristic		White plus non-white			White		Non-white	
		Male plus female	Male	Female	Male	Female	Male	Female
Age	All ages	72	32	40	29	34	3	6
	Under 20	5	4	1	3	1	1	0
	20-29	24	11	13	10	10	1	3
	30-39	14	5	9	4	6	1	3
	40 or over	29	12	17	12	17	0	0
Psychiatric classification	Schizophrenia	35	13	22	13	18	0	4
	Behavior disorder	14	10	4	8	3	2	1
	Character disorder	10	7	3	6	3	1	0
	Other	13	2	11	2	10	0	1
Was on drugs	Tranquilizer only	58	26	32	24	27	2	5
	Anti-depressant only	2	1	1	1	0	0	1
	Tranquilizer and anti-depressant	9	4	5	3	5	1	0
	None	3	1	2	1	2	0	0
In school on ward	All ages	32	20	12	17	8	3	4
	Under 20	4	3	1	2	1	1	0
	20-29	20	11	9	10	6	1	3
	30-39	4	3	1	2	0	1	1
	40 or over	4	3	1	3	1	0	0
Was in Fountain House program		18	9	9	7	8	2	1
Never was in Fountain House program		54	23	31	22	26	1	5
Was in hospital training or industry		27	15	12	12	9	3	3
Never was in hospital training or industry		45	17	28	17	25	0	3

cont'd

Table 2 cont'd

Some characteristics of patients discharged

Characteristic		White plus non-white			White		Non-white	
		Male plus female	Male	Female	Male	Female	Male	Female
Initial prognosis	A	4	2	2	2	2	0	0
	B	45	19	26	16	23	3	3
	C	23	11	12	11	9	0	3
Deafness in family	Parent and sibling	2	1	0	1	0	0	0
	Parent, no sibling	0	0	0	0	0	0	0
	Sibling, no parent	4	4	0	4	0	0	0
(Not mutually exclusive)	Spouse	17	1	16	1	16	0	0
	Child and sibling	1	0	1	0	1	0	0
	Child, no sibling	2	0	2	0	2	0	0
	Sibling, no child	1	0	1	0	1	0	0
	No child or sibling	14	1	13	1	12	0	1
	Other relative only	4	3	1	3	1	0	0
	None	42	21	21	18	17	3	4
	Unknown	3	2	1	2	0	0	1
Continuity on the ward	Final discharge only	56	28	28	27	23	1	5
	Interim discharges and re-admissions	16	4	12	2	11	2	1
All discharged patients		72	32	40	29	34	3	6
Months on this ward	36 or over	10	2	8	2	7	0	1
	24-35	11	8	3	7	2	1	1
	12-23	21	13	8	11	6	2	2
	6-11	8	4	4	4	3	0	1
	Under 6	22	5	17	5	16	0	1

disorder, and 4 had other psychotic illness. Seventeen of the patients were receiving tranquilizers alone, 3 received a combination of tranquilizer and antidepressant medication, and treatment for 4 of the patients currently included no medication at all.

The comparable figures among the 72 discharged patients are 32 males and 40 females, with 43 below the age of 40 and 29 above. With statutes excluding the admission to our unit of anyone under 16 years of age, the largest concentration of discharged patients—24 in all—is still young, clustered in the 20 - 29 age group. The finding is in line with our continuing emphasis on reaching out to younger patients, as early as possible in their illness, to prevent their drift to prolonged disability, emotional stagnation and institutional regression. The fact that 29 patients above the age of 40 were also discharged, however, emphasizes the fact that it is never too late to intervene. Of these 29 patients, several had had more than 10 years' hospitalization and the outlook for most was for an indefinite period of custodial care.

Our mission as an adult service does not permit us to undertake the direct treatment of children in need of hospitalization. In a number of cases, however, we have been able to arrange for admission of deaf youngsters to the children's or adolescent unit of the Rockland State Hospital. From there they may attend part of our in-hospital program on a day-to-day basis. Our experience with these youngsters, as well as with others encountered in the preventive program at the school for the deaf, has emphasized the limitations of such makeshift arrangements. An extended care facility for deaf children and adolescents with psychiatric illness emerges as the most urgent unmet need in the psychiatric program. Effective intervention at this

stage could forestall more enduring psychopathological damage and would increase the likelihood for success of those rehabilitation procedures that presently must await the child's 16th birthday.

The diagnostic distribution of the discharged patients is perhaps more representative of the patient population as a whole than are the figures for the smaller group currently in the hospital. Roughly half of the discharged patients were schizophrenic, a proportion corresponding to that for schizophrenia among all hospitalized patients throughout the state and for all of New York's hospitalized deaf patients. The largest other diagnostic groups comprise those with behavior disorder or with character disorder. These diagnostic categories, with 24 patients in the 2, are constituted by individuals whose character problems were typified by difficulty in adjusting to the norms of the society. Most resorted to immature tantrums or other forms of acting out when faced with the usual difficulties of life or existence in the hearing world. The proportion for deaf hospitalized patients in these categories in our unit is much higher than for hospitalized patients generally, and is higher even than for the statewide population of deaf hospital patients (some 250 deaf persons are hospitalized elsewhere throughout the state). Reasons for the frequency of hospitalization of these cases on our unit include the facts that such problems are most common among the younger age groups, that relief of extraneous pressures can sometimes allow growth and maturation to resume a more appropriate course—and to enable this we will sometimes hospitalize patients who are not psychotic—and that the impulsive actions of these patients are likely to run them quickly afoul of society's strictures. Lagging in emotional maturity, these patients, though young, are older than the age at which their impulsive, often anti-social behavior is likely to be for-

given as normal adolescent mischievousness.

Handling this group has presented a challenge in therapy and management. Ours is a mixed ward where male and female patients spend their waking hours together. This is undoubtedly a socializing influence that provides much in the way of therapeutic benefit, yet, as a society in microcosm and partially closed, it poses much greater opportunity and temptation for anti-social behavior, immediate and direct rage reactions, stealing, and unwholesome sexual acting out. An unusual degree of alertness, tact, and dynamic understanding is required of nursing personnel to forestall and react appropriately to this kind of behavior.

It is interesting that in spite of a history of misconduct on the outside, many of these individuals develop a remarkable degree of sexual and other restraint in the structured social milieu of the ward, and do not seem much discomfitted by the requirement to conform. At the same time, our most noticeable failures relate to certain of these patients, when belying expectations aroused in the staff by their improved behavior, they revert quickly to their former ways once out on their own.

As to medication among patients discharged, Table 2 shows that all except 3 received drug therapy at one time or another during their stay with us. Most patients require a psychopharmacologic agent, most commonly one of the phenothiazine group of tranquilizers, to allay the acute agitation or anxiety that is usually a part of the admissions picture. Others are medicated as required as their clinical course waxes and wanes. What is remarkable, however, is the relatively small number of our patients who required anti-depressant medication. Only 11 out of the 72 discharged received any anti-depressant medication--alone or in combination with other drugs--and those who received only anti-depressant agents number but 2 in the entire series. This may be taken as further support of our earlier observation that

severe depression, typified by psychomotor retardation and recrimination of guilt is relatively rare among the deaf. [6]

These 2 were among the 13 discharged patients not classified as schizophrenic, behavior disorder, or character disorder; their diagnosis was "reactive depression," meaning a depressive reaction to specific overwhelming events (as contrasted with the deep seated so-called endogenous depression, spontaneously occurring from within). Diagnoses in those patients not so far discussed included 3 in the involutional agitated or paranoid category, and 8 others distributed among organic psychoses on the basis of age, arteriosclerosis, or inherited disease (retinitis pigmentosa) (3), psychosis with mild mental deficiency (3), and various neurotic problems (2).

No count shows in the tables for individual or group therapy because all patients, without exception, are treated with both these modalities. As noted earlier, the patient is assigned to a therapist immediately after admission who treats the patient not only on the ward, but in the aftercare clinic as well. This continuity in therapy has paid off handsomely and closely approximates the type of long term therapy available in private practice. For the same reason that our outpatient clinic is staffed by the therapists who take care of the patients on the ward, our program at the White Plains School for the Deaf is also run by the staff of the inpatient service. In this way the inpatient service becomes the nucleus of our activity, reaching out into the community, school, and job situations--in short wherever the individual goes. Follow-up service ceases only after the patient outgrows the need.

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6 Altshuler, K.Z. Character traits and depressive symptoms in the deaf, in Recent Advances in Biological Psychiatry. Vol. 6. (J. Wortis, ed.). New York, Plenum Press, 1964.

Group therapy with deaf inpatients dates from the inception of the inpatient service. It has developed into a dynamic forum where the patients gather twice a week and interact with each other, compare notes, and develop a healthy concern for each other's problems. The sessions provide a chance to learn how others see them and to understand what impact they have on one another and on the group as a whole. Growing in therapeutic sophistication over the years, the level of group discussions ranges from the everyday problems of life to thoroughgoing enquiries around feelings of maternal rejection or the causes and consequences of distorted, misdirected reactions of rage or dependence. New members come in as the old ones leave, maintaining a continuity that has yielded norms and traditions for the group itself. New arrivals pick these up quickly, without persuasion, and benefit from the support of identity of a shared group. We believe group therapy has been a vital factor in the therapeutic results obtained, and the recent addition of video tapes during the sessions has added still another dimension to its effectiveness. Replay of these tapes to the group members aids the development of an increasingly keen and accurate self-awareness. By giving them the unavoidable chance to see themselves as others see them, its therapeutic implications are obvious.

High on the list of management priorities is the inclusion of patients in the ward's school program, made effective by the appointment of a part-time and later full-time teacher for the deaf. While the teacher's primary effort is to improve patients' abilities in basic English and skill of communication, he also teaches arithmetic and other practical academic subjects. A concerted effort has been made to mold all ward programs so that whatever happens may become a part of the learning process. Situations of conflict and disagreements are fully discussed in the group and

individual sessions, and the teacher may use such situations as taking-off points for instruction in academic, social, or vocational areas. We have often been questioned about the need for a school program on an adult ward, an unusual adjunct in any State Hospital. But the educational lag of most of our patients, older as well as younger, classifies them as juvenile dropouts, and as such they may benefit greatly from the teaching program offered.

The school experience is also therapeutic, since it provides each patient a basis for hope in his progress and improvement. Thirty-two of the 72 patients that were discharged were included in the school program and all but 4 of these were in the age group under 40. Had the full-time teacher been available from the beginning, this proportion would probably have been still higher; for at the close of the project, 18 of the 24 patients on the ward were attending school, representing 75% of the total ward population and about 84% of those under 40.

It is well known that isolating the hospitalized patient from the cross-currents of society prolongs his illness. To prevent this from happening, we have always encouraged home visits, visits by members of the family and friends, picnics, and visits to the museums and places of interest in New York City with deaf volunteers or our own social service personnel. Visits to the ward by deaf and hearing groups, interested in the problems of the deaf, have also been welcome. These attempts at socialization keep hopes alive, broaden the patients' perspective, remove many of the feelings of isolation, and ease—by gradual acquaintanceship—the transition from hospital to community life. Most prominent in this connection has been the Fountain House program already touched on, in which 18 of the 72 discharged patients participated. At the close of the project, 10 of the 24 inpatients were also part of the

special Fountain House day visiting program. Experience with the halfway house will be described in a later chapter (see the chapter, Rehabilitation Procedures). What should be emphasized here for the halfway house is the chance it provides for the patient to develop some autonomy while learning the limitations that go with autonomy—and to pursue both goals in a safe and structured setting that includes daily return to the ward. Thus, patients may test themselves in relation to the outside world, yet retire and rest from the effort.

On the grounds of the progressive State Hospital in which the deaf unit is situated are stores, vocational training facilities, and pre-industrial shops. These have proved to be a boon for the deaf patients. With the close tutelage of our staff to ease them into a situation that is not tailor-made, patients begin to learn the disciplines and requirements of a trade, and they have a chance to work with their hearing counterparts. This experience promotes a more realistic attitude towards work and the social pressures that go with it, and of course provides more grist for the mill of group discussion and therapy. Twenty-seven of the discharged patients had participated in this aspect of the program, and 9 of the 24 remaining inpatients were also receiving in the hospital some kind of training or pre-industrial placement. These 9 patients, plus the 10 inpatients in the halfway house visiting program, indicate that about 3/4 of the on-ward patients at any time are actively engaged in rehabilitation directed toward early return to the community. Thus, patients are constantly kept aware of the hearing world to which they will return.

Other characteristics of general interest in the patient population include level of intelligence, types of deafness, age of onset for patients with acquired deafness, and type and skill in communication. Tables 3, 4, and 5 summarize the data in these

Table 3

All patients classified by intelligence level

I Q level	Number of patients
All patients	96
Under 70, defective	8
70- 79, borderline	23
80- 89, dull normal	19
90-109, average	39
110-119, bright average	5
120-129, superior	2
130-139, very superior	0

Table 4

All patients classified by type of deafness
(congenital or acquired) by age of onset

Age of onset	Total	On the ward	Discharged
All ages	96	24	72
Born deaf (congenital)	42	5	37
0-2 years	33	13	20
2-5 years	12	5	7
5 years or over	9	1	8

Table 5

All patients, classified by type of skill of communication

On the ward or discharged	All types			Manual			Mixed		
	Total	Good	Poor	Total	Good	Poor	Total	Good	Poor
All patients	96	75	21	86	72	14	10	3	7
On the ward	24	16	8	22	15	7	2	1	1
Discharged	72	59	13	64	57	7	8	2	6

areas.

Intelligence level follows a slightly skewed distribution, with 8 defectives and no individuals in the very superior range. The bulk of cases, 58 of the 96, cluster in the dull normal to normal range. Although the given scores refer to performance I.Q., generally less diminished by deafness than scores of verbal tests, conservative interpretation advises that some proportion of our patients in the dull normal range would in fact test as normally intelligent, if not for the cognitive gaps due to deafness. The fact that 7 of the 96 fall in the bright average or superior range is also remarkable and shows that mental illness spares neither the defective nor intelligent.

Forty-two of the total were known to be congenitally deaf (Table 4). Three of these patients were known to have deaf parents, 8 at least one deaf sibling (without deaf parents, see Tables I and 2), 2 had deaf children, and 5 had deaf relatives other than their spouses or any of the aforementioned; the remainder knew they were born deaf but were unaware of other deafness in their families. This proportion of congenitally deaf must of course be construed as a minimum figure; a number of persons who claim that their deafness was caused by vague maladies in the first years of life are most likely congenitally deaf in fact.

Oral communication by itself did not exist in our patient population, in spite of the fact that many of our patients were trained in oral methods (see Table 5). All patients with any skill in communication at all, and regardless of their early training, knew and used manual language as well. In the tables and discussion, therefore, "mixed" communication refers to patients that attempted or relied upon oralism as a serious adjunct in communication, while "manual" means those whose oral skills were either non-existent or entirely unused. As would be expected in a mentally ill

and low achieving group, poor skill in communication was not unusual (21 out of 96, Table 5). "Poor", in some of the cases, actually means non-existent. The data also indicate, surprisingly, that half the patients (7 out of 10) that attempted seriously to use oral communication were poor in communication. Another interesting surprise is that 75 patients were considered to have good communication skill, despite both deafness and their illness. Seventy-two of these communicators were manualists, and of the total of 96 patients,86 were manualists.

Data on initial prognosis, frequency of hospitalization, and length of hospital stay are of general interest as well as having particular bearing on the evaluation of results of our program (see Tables 1, 2, and 10). Results will be taken up in the succeeding section of this report. Here it will suffice to note that of those discharged, 4 had impressed our staff as having a good prognosis, 45 as guarded in outlook, and 23 as definitely poor. For those on the ward at the end of the project, there was none with good prognosis, 8 for whom expectations were guarded, and 16 with a poor outlook. The totals then are 4, 53, and 39 with good, guarded, and poor prognosis.

It should be emphasized that while the project ended, the unit and the program continued as part of the State's mental hygiene facilities. Thus, patients on the ward as of the 30th of June 1969 are not to be classed as failures, but as patients that will continue treatment.

Among discharged patients, length of stay on the special unit varied as shown in Table 2 from more than 3 years to less than 6 months. As a matter of fact, 21 of the 72 discharged patients were on the special ward from 1 to 2 years, and 22 were on it less than 6 months. It must be emphasized that time on this ward, added to lengthy periods of hospitalization elsewhere before admission to our unit, not infrequently

totaled up to 10 or more years (not shown in tables here).

It is of some interest to observe the continuity of the stay of patients on the ward, especially for those discharged. Table 6, extracted from Tables 1 and 2, shows that of the 72 patients discharged, 16 had been discharged previously from the ward but readmitted, whereas 56 of the 72 had been on the ward continuously until discharge. (Length of stay on the ward, it will be recalled, is shown at the end of Table 2.) Of the 24 patients remaining on the ward, 7 had been out and back again, and 17 had never been discharged. It must be remembered, however, from Table 1, that 8 of these 17 had been on the ward less than a year, 6 actually in fact less than 6 months, and thus had little chance to reach a point where their discharge could be considered.

Recidivism happens for a number of reasons. Recurrence of illness, to be sure, is one. But failure on a job, derangement of living arrangements, altered family circumstances, and even misunderstandings on the part of authorities contribute no less a part. The conception in treatment is to achieve a remission, prepare the groundwork, explore, instruct and aid the patient, discharge him under supervision, and follow him closely. If circumstances require a temporary return to the hospital, we accept it with no sense of failure and the process is started again from whatever point it has reached. We have attempted to instruct all cooperating agencies in this viewpoint, for with the mentally ill, and especially the doubly handicapped, all tries are tentative. Programs must be designed and tried seriatim, and the concept of closure of a case is generally inapplicable.

Table 6

All patients, discharged and on the ward, classified by white and non-white by sex by continuity of stay on the ward (one or more discharges with re-admission, or final discharge only)

Characteristic	White plus non-white			White		Non-white	
	Male plus female	Male	Female	Male	Female	Male	Female
All patients	96	43	53	37	42	6	11
One or more re-admissions	16	4	12	2	11	2	1
Final discharge only	56	28	28	27	23	1	5
Discharged	72	32	40	29	34	3	6
One or more re-admissions	16	4	12	2	11	2	1
Final discharge only	56	28	28	27	23	1	5
On the ward	24	11	13	8	8	3	5
One or more re-admissions	7	3	4	2	3	1	1
Final discharge only	17	8	9	6	5	2	4

RESULTS AND EVALUATION

Psychiatric evaluation poses a host of problems that revolve around nebulous concepts of cure and improvement and difficulties of prediction and control. Such difficulties are magnified in a sample such as ours, for it is partly generated spontaneously, as new cases arise and are admitted, and partly selected, as our team roves the State following and evaluating patients hospitalized elsewhere and selecting from chronic wards those with some hope of rehabilitation. Moreover, with a group that is multiply handicapped, it is difficult to assess results in strictly concrete terms. Joys and heartbreaks are involved in each step of advancement from emotional disability to emergence as a self-respecting, productive member of society. Each step is difficult to measure, and improvement may be real even if it stops somewhere along the way. Thus, a mere statement of facts and figures, while relevant and necessary, is not entirely adequate, and we hope that succeeding sections will enlarge the reader's view of the subtler nuances and humanistic complexities of our work.

In general our results appear to be good. In the first 3 years of the special ward's existence, the project prior to this, 22 of 50 patients brought to the unit were discharged. Obviously, those chosen as the first to fill the ward--transfers from other hospitals at the time--were patients thought most likely to benefit from the newly provided services. As time went by, the pool of such good cases was emptied, and when the current project began we had commenced the transfer of the more chronic "incurables," for a trial of treatment, while continuing to admit fresh new cases wherever found in the State. Despite this shift, the new services made

possible through the present phase allowed us to discharge 72 of a total of 96 patients served; only 10 of the discharged were returned to other hospitals, and of the 24 remaining on the ward, several are improved, awaiting discharge and further benefits of training.

In what follows, we shall first survey the discharged group to see what features may be associated with success. We shall contrast actual results with 2 types of prediction: one will represent the prognoses made by our staff arrived at in conferences soon after the patient is admitted; the second will be the independent prognosis of a physician outside our unit, but with long years of State service and experience, his prognosis being based on what would be expected for comparable hearing patients in the usual setting of a State Hospital. In both evaluations, each patient serves as his own control.

Table 7

All patients, on the ward and discharged,
classified by result by level of education

Level of education (highest grade completed)	All patients			On the ward		Discharged	
	Total	Improved	Unimproved	Improved	Unimproved	Improved	Unimproved
All levels	96	68	28	10	14	58	14
Under 5th grade	27	14	13	3	7	10	6
5th or 6th	12	9	3	1	2	8	1
7th or 8th	33	24	9	4	3	20	6
High school	22	19	3	2	2	17	1
Some college	2	2	0	0	0	2	0

Dr. Eric Laury of the Rockland State Hospital was kind enough to study and review our records and supply these predictions.

Table 7 summarizes educational achievement against improvement or no improvement. The data suggest that favorable prognosis and successful rehabilitation go along with higher levels of educational achievement. Thus, of 20 patients discharged and with high school or college education, all but 1 were improved. Among the 35 with 5th to 8th grade education, 28 were improved and 7 unimproved, but only 10 of the 16 discharged patients with less than 5th grade education were classified as improved. For patients remaining on the ward, the improved and unimproved are about equal, regardless of education.

Table 8

All patients classified by type and skill in communication, by result, improved and unimproved

Result	All types			Manual			Mixed		
	Total	Good	Poor	Total	Good	Poor	Total	Good	Poor
All patients	96	75	21	86	72	14	10	3	7
Improved	68	57	11	63	56	7	5	1	4
Unimproved	28	18	10	23	16	7	5	2	3
On the ward	24	16	8	22	15	7	2	1	1
Improved	14	10	4	13	10	3	1	0	1
Unimproved	10	6	4	9	5	4	1	1	0
Discharged	72	59	13	64	57	7	8	2	6
Improved	54	47	7	50	46	4	4	1	3
Unimproved	18	12	6	14	11	3	4	1	3

As shown in Table 8, 54 of the 72 discharged patients were considered improved (24 male and 30 female) and 18 (8 male and 10 female) unimproved. The figures for

the unimproved include the 10 patients transferred to their hospital of origin. The same table shows that 64 of the 72 discharged patients communicated primarily by sign language. Only 8 patients used oral communication enough to be classified as "mixed." There is no evidence from our figures that ability to communicate orally is any help toward improvement. It must be noted, however, that most of our patients classified as mixed were poor in communication. It may be that truly good oralists, if we had them, would show some advantage. In addition, it is possible that patients with good manual communication may find adjustment to the ward least difficult, as manualists form the majority of the patient population.

Table 8 also classifies patients according to skill of communication. It appears that patients with good ability in communication may have greater likelihood of improvement. Patients on the ward are of course heterogeneous--long term patients along with recent admissions that may soon change from unimproved to improved.

We believe that the observed results come from diligence and the special qualities of the service. All staff members are able to communicate manually, and there is no persuasion regarding the mode of communication that a patient should use. Patients choose their own natural style and method, and for those with little or poor communication, we resort to systematic pantomimes. In the non-specialized setting of the usual mental hospital, where there is not such readiness to accept and capitalize on communication in whatever form it comes, most of these patients would probably have not seen any benefit. Those with poor communication would not be reached at all, and those whose communication was good but manual would be reached but little better.

Table 9 shows no evidence that either type of deafness (congenital or acquired) or age of onset of deafness in the acquired group bear any relationship to results among our discharged patients.

Let us turn now to a further effort to evaluate the results. As noted earlier, we shall approach this by comparing actual results with prognostic ratings made soon after a patient was admitted. One such rating is made by an outside expert, the "independent" prognosis. The other is made by our own staff. Both prognoses are made on the basis of the patient's history, diagnosis, severity of illness, the facilities for treatment available, and of course, the previous experience of the prognosticator. Having been with our unit since its inception, our staff members might be more optimistic than the independent evaluator. But even the prognoses made by our staff would have to be based on the ward's experience before the present project was initiated and would not take into account in any meaningful way the impact of the more extensive current program. This impact was in fact measured by comparison of early predictions with actual results; the general principle might be that differences that occur from the results expected by a sophisticated group of predictors should be ascribed to the new program.

Staff evaluations ranked patients in 3 prognostic categories. Prognosis A or good, was a patient who was deemed to have a good chance of ultimate rehabilitation and return to the community; B, guarded, meant that the outlook was cloudy, and that while rehabilitation was a possibility, it was not at all certain. C, poor, carried with it the implication that improvement was unlikely and that a lifetime of hospitalization was a distinct possibility.

Table 9

Discharged patients classified by type of deafness

by sex, by result; by age of onset by result

Result	Total	Congenitally deaf			Deafness acquired		
		Male and female	Male	Female	Male and female	Male	Female
Discharged	72	37	17	20	35	15	20
Improved	54	25	10	15	29	14	15
Unimproved	18	12	7	5	6	1	5
Age of onset							
0-2					20	9	11
Improved					15	9	6
Unimproved					5	0	5
2-5					7	2	5
Improved					5	1	4
Unimproved					2	1	1
5 or over					8	4	4
Improved					7	4	3
Unimproved					1	0	1

Table 10 summarizes the data on the predictions for all patients, those discharged and those on the ward at the close of the project. Four of the 96 patients treated during the life of the project had prognosis of A. At the end of the project, all 4 of these patients were discharged as improved, the 2 males placed in jobs, and the 2 females as homemakers to their families. None remained on the ward.

This same table also gives an account of the 53 patients with prognosis B, less favorable. Of these 53, 19 male and 26 female were discharged, and 8 were still on the ward. Three of the discharged (2 male and 1 female) were transferred back to other hospitals, unimproved. Of the other discharged B-patients, 17 (8 male and 9 female) were placed in jobs, 7 (4 male and 3 female) in training programs, and 3 (2 male and 1 female) in sheltered workshops. Ten females resumed their role of homemaker, and 5 patients (3 male and 2 female), while in the community and functioning marginally, were not gainfully employed. Eight of the patients with prognosis B were on the ward at the close of the project, but 3 had already improved. To sum up, of the 53 patients with a B-prognosis, 8 remain in treatment on the ward and 45 were discharged, 3 to other hospitals. All but 5 of the 42 returned to the community were working, training, or functioning in the home--no small achievement in 3 years for a multiply handicapped group deemed before the present project to have at best a 50:50 chance to go back into the community.

Now we come to the 39 patients with the poorest prognosis, the C group. Of these, 23 (11 male and 12 female) were eventually discharged, while 16 (9 male and 7 female) were still on the ward at the end of the period in review. For 7 of the discharged (4 male and 3 female), little improvement had been attained and they were transferred for less intensive care to other hospitals. The remainder (16 in

Table 10

Prognosis compared with results, all patients

Prognosis	Result	Male plus female	Male	Female
A	Total	4	2	2
	Discharged	4	2	2
	Placed in jobs	2	2	0
	Homemakers	2	0	2
	On the ward	0	0	0
B	Total	53	20	33
	Discharged	45	19	26
	In a job	17	8	9
	In training program	7	4	3
	In sheltered workshops	3	2	1
	Homemaker	10	0	10
	Unemployed	5	3	2
	To other hospital	3	2	1
	On the ward	8	1	7
	Improved	3	1	2
	Unimproved	5	0	5
C	Total	39	20	19
	Discharged	23	11	12
	In a job	2	2	0
	In training program	1	0	1
	In sheltered workshop	2	1	1
	Homemaker	1	0	1
	Unemployed	10	4	6
	To other hospital	7	4	3
	On the ward	16	9	7
	Improved	10	5	5
	Unimproved	6	4	2

number), returned to the community, 2 of whom (both men) were placed in jobs, 1 (woman) in a training program, and 1 man and 1 woman in sheltered workshops; 1 woman went back to homemaking and the other 10 (4 males and 6 females) were able to maintain themselves outside the hospital, though remaining unemployed. Ten of those still on the ward with prognosis C also improved. Thus, 16 people who without the services of the project would have been likely to remain hospitalized for life returned to some level of function in the community, and another 10 are likely to join them.

A total of 10 persons of the 96 served during the period of the project must be considered failures and had to be transferred back to other hospitals. All 10 represented chronic cases rotated through the unit for a trial of treatment, a last hope for rehabilitation. (The shortest continuous period of prior hospitalization in this group was 3 years; 1 case only was hospitalized so short a time). After failure of our most intensive efforts, and as the pressure for bed-space to accommodate new arrivals increased, we reluctantly returned these patients to the hospitals serving their locales of origin.

The second measure of evaluation contrasts actual results with independent prognostic ratings. The Appendix reports for all patients age and sex and certain features of prognostic value (diagnosis, years of hospitalization to date). The independent prognosis obtained in each case by review of the patient's history and record is also in the Appendix, along with the actual result and a summarizing comment. The prognoses were made by Dr. Eric Laury, a board qualified supervising psychiatrist with some 14 years of State Hospital experience. The prognostic categories are defined as follows:

Poor — Patient will probably remain chronically hospitalized for life.

Guarded — No real improvement expected, may be out of the hospital briefly, but will probably be in the hospital more than out for the balance of his life.

Fair — Some improvement expected, probably will be out of the hospital more than in, although exacerbations of illness are expected.

Good — Chance of permanent rehabilitation with no or occasional brief returns to the hospital.

Table 11

Independent prognosis compared with actual results, all patients

Independent prognosis		Actual result			
		Good	Fair	Guarded	Poor
Total	96	20	37	19	20
Good	1	1	0	0	0
Fair	28	12	9	6	1
Guarded	16	3	11	2	0
Poor	51	4	17	11	19

In using any one of these categories to classify an actual result, we imply that a patient has in fact fulfilled the expectations that the category describes.

The prognoses were offered without regard to the patient's deafness and with the assumption that patients would receive the intensive and then custodial care that is available under standard state hospital conditions. Not being acquainted at close range with the work of our unit, one might expect such prognostications to be less

optimistic than those made by our own staff, and indeed they turned out to be so.

Table II summarizes the results detailed in the larger Appendix. It reaffirms the results noted earlier: of 51 patients with poor prognoses, actual results turned out to be good or fair for 21. Similarly, 14 of the 16 patients with guarded outlooks have achieved good or fair results, as well as 21 of the 28 with an originally fair prognosis. All those with actual results of good, and all but 7 rated fair, have been discharged from the hospital. Of the 51 patients with original prognoses in the poor category, 13 have been discharged. Seven are working in the community, 3 are in training programs, and 3 are effective homemakers. For the 16 patients in the guarded group, the comparable figures are 5 working, 1 in training, and 4 homemakers.

In addition to the obvious personal benefits derived by a person leaving hospital confinement to contribute productively to his own support and fulfillment, it should be emphasized that there is also a significant financial yield. Current cost estimates for New York are $11 to $13 per patient per day in a state hospital; each patient year averted saves a minimum of $4000.

The data are so cogent that further comment is virtually unnecessary. The program has yielded demonstrable results. It is now a permanent program within the mental hygiene system of the State of New York.

REHABILITATION PROCEDURES

Halfway House Program

Up to this point, we have presented in the main statements of general background, facts, and figures. Here we will shift to a more discursive mode, expanding on certain aspects of the rehabilitation program and recounting some of the incidents and experiences during its course, in order to convey a more comprehensive and ongoing sense of the program as it functioned. To review briefly, the extension of rehabilitation services into the community developed because of recurrent obstacles we encountered in trying to find housing when patients had no families to return to, and the unfamiliarity and resistance of community facilities when it came to working with the disturbed deaf patient. It became obvious that other housing arrangements had to be made available and that indoctrination of community agencies and direct training of their personnel was essential if the forward movement made by the patient on the ward was to be continued in the community.

Even before the present project was begun, our staff had explored with Fountain House the question of whether they could extend their service, geared for the hearing ex-mental hospital patient, to discharged patients with the additional handicap of deafness. The period of trial and error that followed made the Fountain House staff aware of the extra time and effort needed for work with the deaf and led to including funds in the project's design for a social worker at the House to devote 2 full days a week to 4 patients, and thus provide the more intensive supervision required to open the full program to the deaf.

The nuclear team, then, comprised the rehabilitation counselor and social

worker based at the unit for the deaf, and the second social worker working out of Fountain House. When the project started, the counselor, under whose overall charge this segment of the program was to function, and the unit social worker also undertook to organize a corps of deaf volunteers. Some of these volunteers assisted at the Fountain House program and, together with the project's social worker, visited deaf members at their homes and helped teach patients--new to the community--how to travel to appointments at medical clinics, welfare offices and the like. One volunteer brought Captioned Films to Fountain House and also tutored the social worker there in manual language, notably enhancing the worker's skill in a short time.

As a day facility, Fountain House provides for its members a variety of social and vocational rehabilitation programs, each under the supervision of social workers. By working in the kitchen and dining room, a total restaurant operation where dinner is prepared on a large scale, members learn food purchasing, cooking, clean-up and waiting on and busing tables; a smaller snack bar, open during the hours that the kitchen is closed, operates in a similar fashion. A clerical department offers experience under office conditions in typing, filing, switchboard operation and work with an IBM calculator. The housekeeping unit, in charge of cleanliness for the entire building, teaches domestic and janitorial chores. A weekly evening social program and recreational activities during special weekend hours are also offered, and through a day visiting program, patients still hospitalized are enabled to become familiar with the House and with bus and subway travel before discharge, yet return to the hospital at the end of each day.

Equally important for our purposes are the apartment program, whereby

apartments are let to 2 or 3 members each--who pay rent directly to Fountain House--and the organization's transitional employment program. Fountain House established the latter by recruiting community industry, including department stores, restaurant chains, manufacturers, and collating firms to hire groups of ex-patients for relatively unskilled jobs. A social worker accompanies 8 to 10 members to these jobs, which--divided into half day sessions--allow 2 groups to benefit from each placement. The social worker takes over for absentees, assuring employers the completion of their work. After proper work habits and adjustment to the world of work have been established, many members go on from transitional employment to full-time employment.

All of these programs were made available to, and were utilized by our deaf patients. The social worker at Fountain House gives a report to the hospital unit's staff conference each month; ongoing problems are discussed thoroughly, and the full staff kept abreast of news and ideas. At the same time she meets new patients and gains an understanding of their problems through their presentation at case conferences. Hospitalized patients benefit, too, by getting to know someone "out there" before embarking on their first visits.

Table 12 shows the distribution of patients served by the several programs. The initial activity is always the visiting program. Not all regular visitors from the hospital continue at the House after discharge, for many patients return to homes that are out of the metropolitan area. Patients who do go to Fountain House generally receive personal adjustment training and a period of evaluation and training in one of the House areas, and then go on to transitional employment or a vocational training program. Some try several programs; one patient worked at 6 transitional employment placements before he was successful, and a number of others were involved in 2 or

Table 12

Deaf patients served in Fountain House setting
April 1, 1966 to July 1, 1969

Fountain House service provided	Number of patients served
Visting program	28
Personal adjustment training (PAT) and work in a Fountain House area	18
Transitional employment placement (TEP)	8
DVR sponsored PAT for Fountain House members	9
DVR training programs for Fountain House members	5
Full-time employment	3
Living in Fountain House apartments	6
Social services provided for by F. H.	
Welfare referrals	10
Social Security disability	4
Medical clinic referrals	5
Captioned films for the deaf	All that attend
Total in-patients	28
Total out-patients (never hospitalized)	4

more.

Cooperative support of a patient's progress through and out of the House program can best be illustrated by tracing the course of a typical case history.

V.B., a congenitally deaf girl, now 29 years of age, had been transferred to the special unit from another hospital even before the beginning of the present project.[7] Born out of wedlock, rejected always, and sent to foster homes at the age of 10, she suffered from severe adjustment problems and psychological deficiencies. At 16 she returned to her mother, now married and with an adopted, hearing daughter. The living situation generated so much tension and such severe behavior problems that hospitalization was eventually necessary.

In the unit for deaf she had been diagnosed as an inadequate or primitive personality, and was involved in individual and group therapy, encouraged in her native talent for painting, and included in the typing program at the hospital. When she was thought ready, she entered the visiting program at Fountain House once a week, and then increased the frequency gradually to 4 days a week. The social worker based at the House and the state DVR counselor assigned to work with the deaf became well acquainted with V.B. well before discharge and a post-hospital plan was developed and coordinated at several staff conferences.

She moved into one of the apartments sponsored by the House and commenced a PAT program there. At the same time, she was seen for after care at Psychiatric Institute by the therapist who had treated her in the hospital, and visited at her apartment several times by the project vocational counselor early in this new experience. When she had adjusted to life in the community and finally accepted the fact that her family wanted nothing to do with her, transitional employment plans were made at the regular staff review. She was placed in a department store and worked there, part-time as a stock clerk for close to a year. During this time she met, and fell in love with a deaf man who expressed a desire to marry her. Her general stability suggested that upgrading her skills might be possible, and under DVR sponsorship she began a diagnostic vocational evaluation at the United Cerebral Palsy Workshop of Manhattan. The goal was an employment which would enhance her skill for the future, and even her fiance was brought into the picture to assist and encourage her. After a number of case conferences, held at the workshop and attended by the DVR

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[7] This patient had been known to our staff and treated since the age of 18. For a description of her in-hospital course and the steps required to prepare her for discharge, see Comprehensive Mental Health Services for the Deaf, Rainer, J.D. and Altshuler, K.Z. (eds), New York State Psychiatric Institute, New York 1966.

counselor, the House social worker, and the project vocational counselor, training in mechanical drafting was decided upon--an effort to utilize her drawing ability in an occupational area where job opportunities are not limited by deafness. At the present writing, she has been married for 4 months, has trained well and diligently and will soon be ready for work.

A slightly different cooperative endeavor is evident in the next case, who--because of difficulties of diagnosis, evaluation and placement--would have languished, indefinitely hospitalized, were it not for the project's special services.

G.B., an obese 26 year old negro female was transferred to the unit in February 1968. Deaf from meningitis at age 2, she had lived in foster homes almost all of her life and was poorly educated. In 1960 she became pregnant; she was unmarried, refused to say who the father was, and had become agitated and displayed psychotic behavior. She was hospitalized and delivered of her baby, who was given up for adoption. Diagnosed as having an excited psychotic state with mental deficiency, she remained in the hospital 8 years, until space was made available for her to transfer to the special unit as part of the program to rotate chronic patients through for a therapeutic trial.

On the ward she adjusted well and was cooperative; she functioned at the borderline level of intelligence, and the earlier diagnosis was suspended. After she received individual and group therapy, and was evaluated for vocational potential, she entered the visiting program at Fountain House. She was shortly discharged outside the House facilities and lodged in a female residence[8] for ex-mental hospital patients that was enlisted for a time to cooperate with us. The social worker, rehabilitation counselor and even her theapist took turns at visiting her at the new abode, and daily visits and a PAT program were arranged at Fountain House.

As she was completing this course, and after visits by the DVR counselor to observe her in training, staff review laid plans for the next phase. DVR subsidized first an evaluation and then a rehabilitation program at the New York Needle Trade School where the patient learned to be a sewing machine operator. She was subsequently placed in full time employment in a factory and has continued to do very well. Her employer reports that she is one of their most satisfactory employees; she continues to participate in the Wednesday evening social program at Fountain House and see her theapist monthly in the outpatient clinic.

It should be obvious from these case studies that an emphasis on rehabilitation

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8 The Cobble Hill Residence in Brooklyn, New York.

figures prominently long before the patient is discharged. The project counselor establishes rapport and begins to administer tests and explore vocational interests and goals as soon as the doctors' evaluation permits. Patients are placed in hospital industry wherever feasible and observed by the counselor in such practical work settings as hospital store, serving room, pre-industrial shop, typing class, and cooking class. The supervisor's evaluation in each of these primarily pre-vocational situations aid the counseling process by highlighting work habits, punctuality, neatness, ability to get along with others, and the patient's acceptance of supervision and authority. Thus, post-hospital plans are crystallized early.

The project's rehabilitation counselor leads the team charged with the development and implementation of rehabilitation plans. Together with the unit's social worker, she is in contact several times a week with the social worker at Fountain House, the DVR counselor working with the Deaf, and other agencies. The team has opened a number of facilities previously closed to the deaf. Referral to these agencies, interpretation to them of the function of the hospital ward and the particular problems of each multiple handicap, and allaying their anxiety--to keep the liaison smooth--requires a good deal of time, talent, and tact. The unit's psychiatric social worker joins the counselor in this task and also carries a major responsibility for promoting social adaptation of the patient, both before and after discharge. DVR sponsors the work training programs at Fountain House and at other agencies as well.

The previous case histories focussed on the cooperative endeavor in the use of House and agency facilities, as patients were supported through their progress in a rehabilitation course. The following vignette touches on a different situation, and

highlights the social work role in minesweeping a patient's path clear of unintentional, yet damaging, family sabotage.

> S.K., a 25 year old, congenitally deaf, white man, was transferred to the special unit after 6 years at another hospital. Despite the long term illness and the diagnosis of chronic undifferentiated schizophrenia, he made sufficient progress to make discharge and rehabilitation a visible possibility. He had been noted to be more upset after visiting day and--in preparation for his return home--the social worker was assigned to counsel with the patient's parents. Both parents were deaf, the father a passive, cooperative man, and the mother a rigid, tense woman, prone to being uncooperative and quick to give an agitated, unrealistic defense of any of her son's inappropriate behavior. After I year on the ward, the patient was discharged to the after-care clinic and placed on a DVR supported training program at a cooperating agency.
>
> The social worker visited the patient regularly, and also the family. The mother complained that hospitals were ineffective and DVR did not do enough. She was embarrassed that deaf friends thought her son was insane "because he visited that clinic," and angered by the low wages paid him while in training. She also felt that the hospital had held him too long and he had probably only had pneumonia anyway.
>
> The patient missed days at the training program frequently and finally stopped coming altogether--his absence being noted each time through our close contact with the training center. In a series of home visits the worker discovered that the mother had ordered the patient to stay home to "save him from slavery and slave wages"; even the father--obviously influenced--pitched in with "Don't you see how hard I've worked for 35 years! Don't be a sucker." It took 6 months of steady family work to enable this patient to attend the program regularly and to build a somewhat separate identity and more socially conforming opinion. The sessions, with parents and son or parents alone, slowly allowed for clarification of the difference between working to earn and working to learn to work; eventually the father even came to feel free enough to disagree--occasionally--with the mother's views.

Other Rehabilitation Programs

As indicated in the above description, DVR has sponsored a number of other programs in addition to those for patients at Fountain House. To support our patients through such training demands close touch with the training personnel and a close liaison with the state DVR counselor. Like the social worker placed at Fountain

House, the state DVR counselor reports monthly at staff conference, and the project's rehabilitation counselor is in contact with both professionals at least once a week. Early contact with patients facilitates planning of rehabilitation programs and starts the flow of appropriate papers; thus waiting periods between discharge and involvement are reduced to a minimum. Along with the entire staff of the project, the DVR counselor has also been trained to communicate in sign language.

Table 13 compiles the data for patients served at major agencies whose facilities have been newly extended to work with disturbed deaf persons. DVR again deserves to be commended, for in addition to sponsoring Personal Adjustment Training (PAT) programs for almost all patients entering Fountain House, the Division has supported all the training programs noted in the tables with the exception of those at the Industrial Home for the Blind, and has sponsored several others at various metropolitan commercial training facilities.

The patient sponsored for PAT and other training at the workshop of the Association for the Help of Retarded Children illustrates the value of the combination of close working relationships and DVR's readiness to support. Despite a relative success, she had to be rehospitalized when the living situation with her barely functioning, fragmented family caused an exacerbation of her symptoms. The steady communication maintained with the staff at the workshop while she had been there reassured their personnel and heightened the feeling of cooperative endeavor. The workshop took her back when she was discharged again and DVR again sponsored the attempt. This pattern repeated itself 3 times, with the patient each time staying out for a longer period. At this writing she has been hospitalized again, but the constancy of interest developed led the director of the workshop to assure us of an

Table 13

Other New York agencies open to deaf patients with mental illness

New York agency now working with the disturbed deaf	Number of patients referred and serviced	Results
Association for Help of Retarded Children	1	Employed in workshop, then re-hospitalized
The New York Society for the Deaf	6	3 in full-time regular employment 2 under-employed but living in community 1 re-hospitalized
United Cerebral Palsy Workshops		
Manhattan	2	1 employed in workshop 1 in a training program
Queens	1	1 evaluation completed; patient refused further help
Industrial Home for the Blind	3	2 finished evaluation and training; employed in workshop 1 evaluation completed; patient enrolled and entered training program (printing)

opening once more whenever the patient is ready.

The New York Society for the Deaf was most helpful in the training of our patients and in securing foster home placements for some of the needy ones as well. Through DVR sponsored programs there, patients were also able to advance in remedial and communication training commenced in the hospital. Of 6 patients who received services, 3 have been placed in full-time, regular employment; 2 of the others are functioning marginally, but still in the community, and I has been rehospitalized. Plans in each case were arrived at cooperatively, by the DVR counselor, the staff of the deaf unit, and personnel at the facility. Again, the project's rehabilitation counselor has the primary responsibility for maintaining these close contacts so that problems are spotted early and dealt with promptly, with sparks smothered before a real fire develops. Three patients have been placed at the United Cerebral Palsy Workshops, with I permanently employed, I in training, and I having refused to continue after the evaluation.

The Industrial Home for the Blind operates on funds from the New York State Commission for the Blind and various federal programs rather than being under DVR sponsorship. The special training program and residence there for deaf-blind people has enabled them to help our patients with retinitis pigmentosa--after we spent some time in indoctrination and persuasion. This hereditary illness, characterized by progressive blindness as well as congenital deafness, is often accompanied by severe emotional disturbance. Three patients formerly on the ward are currently in programs at IHB, a pioneering venture, for this agency too had never serviced the emotionally disturbed, deaf-blind before. Services include cane and travel instruction, vocational evaluation and training, and their own workshops where patients earn wages

according to their production. Because these psychiatrically ill and deaf patients have the added disability of blindness, their after-care is implemented through visits to IHB by various members of our staff instead of having the patients come to the after-care clinic at Psychiatric Institute.

Almost all discharged patients but the blind are seen in the outpatient department at Psychiatric Institute by their previous therapist on the ward. Exceptions are those who live and work in Rockland County--and hence return as outpatients to the unit at Rockland State Hospital--and patients who return to homes or placements in upstate areas. In the latter type of case, as much as possible is done in advance of discharge to design and arrange a post-hospital plan. For a patient from Albany, for example, the project's rehabilitation counselor held several discussions and sent all necessary reports and history to the local DVR counselor, to ensure a placement with training and regular supportive psychotherapy in the Sunnyview Rehabilitation Center in Schenectady.

Outpatient Clinic

In the outpatient clinic, most discharged patients are seen for therapy on a once a week basis for at least a year and thereafter bi-weekly on a once a month basis for as long as is necessary. The clinic itself was established, expanded and made permanent as part of the earlier mental health projects.[9] It accepts some 40

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[9] For a thorough description of the clinic development and operation see Rainer, J.D., Altshuler, K.Z., and Kallmann, F.J. (eds), Family and Mental Health Problems in a Deaf Population, N.Y.S. Psychiatric Institute, New York 1963 and Rainer, J.D. and Altshuler, K.Z. (eds), Comprehensive Mental Health Services for the Deaf, N.Y.S. Psychiatric Institute, New York City 1966.

new patients per year. Aside from the ex-hospital patients from our ward who are followed in after-care, only a few have ever been institutionalized. The majority of outpatients are not psychotic but have neurotic difficulties or problems of family or situation, and are dealt with psychotherapeutically or by counseling. Since they are less disturbed and generally functioning in the community, only a small proportion of these individuals (10 in all) required the rehabilitation services that are the subject of the present report. The range of services given these cases also varied widely. Four availed themselves of the Fountain House facilities. In another case, of a 17 year old male drug addict whose motivation for treatment was so poor that he virtually refused to come to the clinic, we could only interpret the problem and give advice to other City agencies when they perforce became involved. When the boy assaulted his stepfather, the therapist assisted the family court and probation officer in their evaluation. Later, we persuaded an addiction center to accept him for treatment. He is visited regularly and we have encouraged some of the staff there to learn sign language. We will no doubt be involved in his referral when he is ready to leave, and should be better able to reach him and work with him personally.

J.S. is a patient at the other extreme. First referred to us in 1963, at the age of 15, he has been an outpatient almost continuously ever since. His many problems followed from an extremely traumatic life history. His alcoholic mother, to whom he was deeply attached, died when he was 12; and his father, also alcoholic, was an inadequate and irresponsible man, completely unfit to support or guide, or to serve as a model for positive identification. The boy had been placed with his aunt, and came to the clinic when he developed an intense fear that he might kill her.

As a patient, he was seen weekly for 4 years, and then at a reduced frequency; he still comes to the clinic periodically when new problems arise. During these years of psychotherapy, our rehabilitation counselor also arranged summer jobs for him through various youth employment services and, when he graduated from secondary school, made arrangements for DVR to finance his attendance at Gallaudet College. He left the college after 1 year, then entered a DVR training program through our efforts; subsequently, we helped locate a job for him with the aid of the New York State Employment Service. Somewhat later he almost lost the house willed to him by his mother, because his father had failed to make the tax payments that were due. The counselor, therapist and lawyer we had found for him through the Legal Aid Society worked closely for several months in order to postpone the city's impending seizure and find a buyer instead. Rather than being penniless, the boy has now a substantial sum of money in trust for him as a result.

Need for Continuous Efforts

It should be emphasized that the kinds of efforts described must be unremitting and available at any time, in order to achieve and maintain the results documented here and in the earlier, statistical section of this chapter. Rehabilitation of the deaf and mentally ill patient is not an easy task, nor one that is finished when the client is placed in--or even terminates--his training. Crises arise at every point in the rehabilitation process and the necessity for close supervision, and interagency communication, cannot be over emphasized. Such communication and the ongoing precaution of continuous phone checks allow for the appropriate person--counselor, social worker, psychologist or physician--to be in almost immediate

attendance whenever necessary. Only through these efforts have we been able to keep rehospitalizations down to 9, and return all but 2 of these to community function.

Housing remains a problem despite our best efforts and the association with Fountain House. Too often, homes are still found only through serendipity or after staff members follow innumerable fruitless newspaper leads. Foster-home placement is an occasional possibility for younger patients, but it involves cumbersome dealings with the City's Welfare Department and its Bureau of Foster-Care, a welter of red tape that has been most unwieldy. Temporarily, through assiduous cultivation, we were enabled to make use of a newly established, private residence for female ex-mental hospital patients; 3 patients were placed there, but after 2 had required rehospitalization, further referrals were not accepted. Such turnabouts are only to be expected, and our policy has been to search steadily for new housing opportunities (the requisites being a level of human understanding and a willingness to face the particular communication problems) and store them in readiness so that propitious moments for discharge will not be easily missed.

PREVENTION: THE SCHOOL PROGRAM

Introduction and General Background

In view of the large number of children and adolescents referred to the clinic in the earlier projects, Drs. Altshuler and Rainer had undertaken a series of regular visits to the New York School for the Deaf during the school years 1963-1964 and 1964-1965. Each year approximately 20 students were seen for individual evaluation, and plans for therapy, modification of goals, or environmental promotion of more healthy development were made and discussed with teachers and other staff members. The need for education of both parents and cottage parents so they might come to an understanding of principles of development was clearly indicated.

A curious lack of group cohesiveness, or interest in and loyalty toward one another, was noted among the young adolescents. Exploratory efforts toward promotion of group interaction and the development of concern for the feelings of others and a sense of mutual responsibility--the precursor of community responsibility--were therefore begun with groups of boys and girls from 10 to 16 years of age. Boys of 12 years and under seemed unable to form group relationships at first. They remained uninterested and uncommunicative with each other, each clamoring for the doctor's attention. Another group, the boys aged 13-16, selected from families where paternal guidance and support were known to be lacking, were preoccupied with violence and fears. Girls of a comparable age were somewhat more mature, aware of others, and more concerned with school work and growth into womanhood. In all, there was a striking absence of any but the most primitive knowledge of sexual function, reproduction, and mutual relationships.

The program therefore was designed to fill these gaps. It consisted of 3 parts, each with its own aims: (a) Individual consultation and treatment for those students posing problems of management or achievement, or reacting to family difficulties, personal frustrations, or neurotic or psychotic ills. Diagnosis, planning and treatment of these cases was to involve teachers and cottage staff and so afford them increasing knowledge gained first hand, in the principles of mental health and normal development and in their application, (b) Direct work with adolescent groups to enhance their abilities to observe themselves and others, to give them a framework in which to define the impact of their own behavior on others, to deepen conceptual grasp and a sense of mutual interest and responsibility, and to provide the facts, a forum, and a trenchant grasp of reasons that underlie rules and roles of sexual and family behavior, and (c) Work with parents of students, both deaf and hearing, and including parents of the younger children and those of almost full grown adolescents. The problems faced by parents of younger and older children were expected to be different and it was hoped that the group situation would offer a chance for exchange of views, for ventilation of guilt, for the supportive reinforcement of feelings that others shared the same kind of difficulties, and for the highlighting of neurotic attitudes that could yield to insight under group scrutiny.

School Consultations

Weekly visits were made to the New York School for the Deaf during the school year throughout the duration of the project. In all, 51 boys and girls were seen over the 3 years, about equally divided between the sexes. Eight were seen the first year, 25 the second, and 18 the third.

The relative reduction in individual work during the first year was due to our effort to broaden the base of services by providing weekly individual teacher conferences. In these meetings with a primary or preprimary teacher, the psychiatrist and members of the school's mental health team (school psychologist and social worker) would discuss all children in the charge of the particular teacher. In line with the preventive direction of the project, teachers were encouraged to outline each child's behavior and to review that behavior about which they had some concern. For children whose behavior was determined to be outside the range of normal, activities to be emphasized or altered and means of alleviating transient stresses were planned. The purposes were to enhance the teachers' general knowledge of normal development, to heighten their perceptiveness in observation and at the same time to afford direct help to the children. Similar discussions took place with selected cottage parents, and a series of lectures and discussions was held with the entire cottage parent staff.

This format was helpful but time consuming, and drastically limited the time available to work with individual students. We decided therefore to conduct this kind of general educative program only once in the 3 years, hoping to repeat it again 3 years later to review the principles with experienced teachers and indoctrinate more recent additions to the staff. Meanwhile we would focus on children posing particular problems and discuss them with teachers, cottage staff and others as the occasion required. In practice, the general procedure that emerged was that referrals were made by teachers through the mental health team, who gathered and presented information to the psychiatrist. The psychiatrist then saw the child and outlined a plan of treatment, for individual therapy, family counsel, environmental

manipulation or further study. Conferences were then held with the appropriate personnel and the plans implemented under the direction of the mental health team, themselves reporting periodically for review and supervision to the psychiatrist.

The most common problems (more than 50% of all cases seen) comprised the so-called primary behavior disorders of childhood and adjustment reactions of adolescence, diagnoses which are comparable but for the fact that they occur at different ages. The behavior was comparable to that seen among similar hearing cases: hyperactivity, disciplinary problems, or regression in younger children; stealing, truancy or academic failure, sexual misbehavior or aggression among the older group. Treatment was most commonly directed at alleviating school, environmental, or family problems, with an occasional case requiring individual therapy for up to several months.

The second most common difficulty (about 1/4 of cases seen) included pupils where organic brain damage was found to be involved in some apparently abnormal behavior. Naturally these children were most often in the younger age range and frequently their deafness had its origin in maternal rubella. Other not infrequent difficulties included frank neurotic problems, occasional cases of schizophrenia, and situations where erratic behavior was secondary to unrecognized presence of below average intelligence.

Through counseling, the intervention of the mental health team, and the cooperative endeavors of teachers and dormitory staff all but 2 of the children were enabled to remain in school. While often representing success, for a number of unfortunate cases this was the best of a bad situation. The organically damaged

and the childhood schizophrenics more often than not require facilities for special care beyond those able to be provided by even the most interested and progressive school, and so do some of the more severe neurotics and behaviorally disturbed. At this point no such special residential hospital--geared for the care of deaf, emotionally disturbed children--exists in this country, a lack that is sorely felt and in great need of remedy.

Adolescent Group Program

On the basis of the experience gained with the previous experimental groups of deaf adolescents, we extended the program to a representative, heretofore undiagnosed group of students comprising a study-hall section of 5 boys and 4 girls ranging in age from 15 to 16 years. All the students knew each other and attended classes together. Starting in September, 1966, the group met continuously on a weekly basis through June 1967. With the nucleus of the group intact, new members were added in September 1967 to fill vacancies created by graduated members. The process was repeated in September 1968 and the program continued to the end of the school year, June 1969.

The weekly sessions in 1966 were quite turbulent. Resistances to establishing a therapeutic relationship with each other and the therapist were manifold. Inattentiveness, reading of school books, numerous questions of an intellectual bent designed to involve the therapist in a private interchange, the formation of small cliques, all made it hard for the therapist to weld the group together into any kind of whole. This problem was taken up with the group; discussion of their attempts to ward off an affective interchange, and their resistance to the group process led to

the expression of considerable frustration and doubt with respect to the value of the group itself. These doubts extended to a discussion of the value of school in general. Several heated debates followed, with a number of students expressing the wish to leave school for work rather than to pursue further education. This topic appeared to trigger the previously uninterested silent and recalcitrant members. The attack directed towards the school and group as a whole succeeded in closing the ranks of the students. A spark of cameraderie seemed to be kindled, with growing awareness of the school's value for each individual. The need for education as a prerequisite for a good job, the securing of a diploma as a source of pride for themselves and their family, as well as hints of a wish for continued friendship served to bring the group together and modify the earlier resistive phase. The potential school dropouts were admonished by the others, and each member of the group seemed to feel his impact on the others for the first time.

In subsequent sessions it became much easier to evoke lively discussions in areas of student interest. Topics such as preparation of work, personal and community responsibility, family living, problems of sex, and courtship--notably absent at that time from the school curriculum--were touched upon for preventive and educational purposes. In general, the focus of the group work was that of fostering knowledgeable and healthy development in the deaf teenager.

Videotape Recording

In the course of the second year of the preventive group psychotherapy program, as part of a national workshop on psychiatry in the deaf, a videotape recording was made of a single session for documentary purposes. During the videotape session

the youngsters showed noticeably more social stress and self consciousness; the ensuing sessions were taken up with discussing these reactions. One member of the group had a dream which was of value in understanding how the fears were symbolized.

In looking back at the education of the deaf child, we noted the extensive use of visual modalities from the earliest nursery school days throughout the years of formal education. During their daily work, the students had become familiar with overhead projectors, film strips, slides and captioned movies. Teaching speech-reading, speech production, modulation and rhythm requires the constant use of visual aids to remind the deaf of the structure of language and to develop a vocabulary which the deaf child never hears. Having been conditioned to pictorial representation from the earliest years of school, the students could be expected to respond to similar techniques in psychotherapeutic work. We therefore began to utilize closed circuit television on a regular basis in 1968.

The weekly videotaped sessions proved exhilarating for everyone concerned. Not only did the group's initial hesitancy and wariness give way to enthusiasm, but the students seemed to be more motivated and responded more promptly when urged to use speech along with the usual modalities of communication. Although attendance was not required, the students were consistently prompt and diligent. Curiosity to see what could be done ran high; intrigue with the electronic magic of the television medium itself undoubtedly minimized the resistance to attending the meetings.

Each session consisted of varying time segments for taping the group's interaction. Following the initial taped portion, a replay and discussion of what had

transpired occupied the remainder of the hourly sessions. Using a zoom lens, good eye-to-eye and close-up contact was established. This feature is of special importance to the deaf, who depend upon face-to-face confrontation in communicating. On occasion a student volunteer would operate the camera. The active involvement on the part of the students enhanced the interaction during the taped segments as well as during the replay discussion.

During these sessions it was possible to explore some typical problems of impulsivity and acting out; an angry exchange could be replayed and facial expressions correlated with provocations and emotional reactions. In observing their own inappropriate behavior, students could even associate it with home situations and parental interactions. The group members were obviously pleased when their own understanding deepened; they were stimulated by a sense of closeness to one another, and would continue to bring up for discussion several family problems and other personal difficulties.

The sessions also served as springboards for the discussion of sexual attitudes and behavior. The boys evinced a greater curiosity to learn more about the mores underlying sexual behavior, whereas the girls were hesitant to discuss sexual activity other than in the framework of a marital relationship. Although maturational lags and a general absence of firm knowledge was evident, many pertinent questions were posed regarding the teenager's dilemma in fathoming the rules, roles, and choices in premarital relationships. The therapist offered assistance in correcting basic misinformation and in helping the group to distinguish promiscuity as an illusory gratification of the need for love from sexual behavior in the course of a meaningful relationship and responsibility in love. Although these issues were explored at

various times and in varying depths, it was clear that the full grasp of the principles underlying sexual behavior would require further attention as part of an overall program of family living and sex education.

The videotape seemed consistently to help in heightening awareness, providing insights, and enhancing interpretations of behavior, so that the underlying abstract concepts could be made more meaningful. The substitution of a picture for a more intellectual presentation (in language) of an abstract concept offers promise for the development of symbolic recall, recognition of similarities, and especially for the development of self restraint as greater empathic awareness evolves. A self image test was devised to evaluate the clinical observations and will be administered yearly to students in the group and to controls.

Parents' Discussion Groups

In the 3 years covered by this report, 38 couples were seen at the child oriented parent counseling sessions at the New York School for the Deaf; Drs. Rainer and Altshuler supervised the discussion groups which were moderated by Dr. Sarlin. The school's social worker and psychologist assisted in the recruitment of these groups and also served as recorders of the session. In 1966, 10 couples with children 5 to 8 years of age were invited. Four to 6 couples (8 to 12 parents) attended regularly and formed the core of the "Young Parents" group. A second group, the "Older Parents" group was drawn from the parents of teenage students in school. Eleven couples comprised the initial group invited with 3 to 4 couples attending regularly.

The parents of the younger children were especially enthusiastic about the

meetings. During the initial phases, uncertainty of purpose, hesitancy in interacting with one another, and dependence on the leader, gradually evolved into a cohesive structure in which the members became interested in each others' opinions and personal problems and in moving towards a greater degree of self direction in resolving their difficulties. Of the 6 couples who attended fairly frequently, during the 1966-67 session, only 2 did not continue in the succeeding academic year (1 moved out-of-town and the second was unable to attend because of personal problems).

Among the parents of the older children, however, poor attendance was the rule. Of 11 couples invited in 1966-67, only 3 to 4 families were represented and then only infrequently at the bi-weekly meetings. With only 1 parent of the initial 11 continuing to attend regularly in the following year, the teenagers' parents group was discontinued in February 1968. During the meetings of the "Older Parents" groups, there had been ample demonstration of the need for counseling. For example a passive mother and an alcoholic father felt their daughter posed no problem, despite the fact that she was shy and introverted to the point of withdrawal from almost all social contacts and activities in the school; one mother's excessive fears of vulnerability were highlighted, fears which led her to prohibit her 18 year old from taking a trip to the city in the company of half a dozen other deaf youngsters; or a mother's efforts to be rid of her 17 year old were apparent, as she tried to rationalize his living at school rather than coming home each day by bus. Massive denial of any problem, parental disappointment with their children and compensatory exalted expectations, frustration in communication with secondary overprotection and overindulgence--all contributed to the parents' resistance to

attending the meetings for exploration of their attitudes and behavior. The "Older Parents" seemed unwilling or unable to reflect on their contributions to their children's behavior; in expressing demands for the school to assume a greater share of the upbringing of the children, they displaced their responsibility with little hesitancy.

Meanwhile the discussion in the group of younger parents covered such matters as overprotection, and guilt over leaving children at school. Problems in communicating with children regarding dangers led to a discussion of oral and manual communication methods. This topic soon involved the parents in a discussion of their own guilt in having a defective child, embarrassment over their child's behavior, and disagreement between fathers and mothers regarding child rearing techniques. Parents brought up their concern over neglecting their hearing children if the deaf child got special attention.

During the 3 year period, some parents asked for more direction in the meetings with topics and readings to be assigned. An attempt was made to compromise between entirely undirected discussions and formal programs.

In summary the 3 year experiment in conducting group discussions with parents of deaf children was fairly successful in the case of parents of younger children, but fell short of its goal in working with the parents of teenagers. The former group were flexible enough to listen to one another, close enough to the original traumas of having a deaf child to explore their feelings, and hopeful enough of the future to grope for answers. In the older group, many years of frustration had led to a withdrawal from the situation, and the sessions were used mainly to look for ways to criticize and to transfer the problems to the school authorities. With some members

of the mental health team having other official functions at the school, some conflicts of role and of interest may have also contributed to the direction this group took.

It is recommended on the basis of these experiences that therapy groups aimed at exploration and changes of attitudes be confined to parents of young children, just entering school or even pre-school, and that meetings with older parents be limited to short-term presentations and discussions of particular topics--e.g. job training, or sex behavior.

Teachers and Houseparents

It would seem obvious that teachers having difficulties with their students would welcome expert psychiatric assistance in trying to fathom the nature of the problem and the possible ways of dealing with it. This was indeed the case when students had clear cut behavior disorders which were disrupting the class and which were resisting ordinary disciplinary treatment. These were the cases which had been brought to the attention of the project's directors in their capacity as psychiatric consultants to the school prior to the onset of the current program. Extending psychiatric assistance to the area of prevention, however, just as predictably ran into some resistance on the part of the teachers who felt threatened, who felt their inadequacies would be exposed, and who in many cases were poorly trained in describing the behavior of their children with less clear-cut problems. Some of the supervising teachers were better at this and served as liaison between the mental health team and the faculty.

The first attempt to go beyond the consultation program with the teachers was

the scheduling of conferences that would deal with individual problems to be sure, but would extend as well to the question of interaction of the problem child with other members of the class and eventually to discussions of the entire class. In order to do this, it was necessary for the psychiatrists to visit the classroom, to sit with the class, and to watch the dynamics and interaction of the teacher and the various class members. These observations also allowed the psychiatrists to form an opinion regarding the individual difficulties of all the children in the class and how these affected both the teacher and the fellow pupils. It was then sometimes possible to discuss the entire picture with the teacher and supervisor and thus help not only the students who started the whole consultation, but the entire group.

During the year this was done we regularly set up individual interviews with each teacher with the expressed purpose of discussing her entire class and all the pupils within it. It was at this point that teachers often showed a good deal of tension and anxiety. Reassurance about their management and assisting them to observe, describe,and understand their charges' behavior, generally coupled with actual visits to the classroom, made it possible to solve most of these incipient problems,and the dialogue that was set up established for the teachers an appreciation of the positive and negative forces in the development of the children. One of the most valuable features of these conferences was the chance to acquaint the teachers with some of the home background of the students known to the school social worker, also with some of the psychological tests of the students known to the school psychologist, but through lack of proper liaison unknown to the actual teachers. House parents and cottage parents were uniformly included in these

conferences since they spend so much of the after hours' time with the pupils. On occasion, gymnasium teachers, art teachers, the school audiologist and other school personnel were brought into these conferences.

During the first summer of the program, the school received a special grant to set up a training course for houseparents during the weeks preceding the opening of school. The psychiatric staff of the project participated in this program and provided 4 mornings of instruction and discussion regarding psychological problems of children and adolescents in general and of deaf children in particular. Many of the potential houseparents had had no experience with the deaf and ranged from well-trained to somewhat undertrained in their background. Much of the discussion had to proceed on fairly concrete levels and a good many of the houseparents ended the week's training with a theoretical but rather naive picture of the problems that lay ahead. This was born out by the fact that a number of them could not adjust to the actual care of deaf children and resigned within the first few weeks of the school year. On the basis of this experience, it became our feeling that the qualifications for houseparents in residential schools were too low, that undoubtedly the pay scale was insufficient to attract younger and more adaptable individuals, and that in any event a much longer training period with inservice preparation was required.

TRAINING ACTIVITIES

During the course of this project, 2 major training workshops were conducted by the directors and staff. The first conference was held in New York in April 1967 and was sponsored by the New York Psychiatric Institute in collaboration with the New York University Center for Research and Training in Deafness Rehabilitation. It brought together 32 psychiatrists from the entire country to share their interest and experience with the deaf and view our program and facilities. The proceedings have been published by the Department of Health, Education, and Welfare as a book, Psychiatry and the Deaf, edited by J. D. Rainer and K. Z. Altshuler.

The second workshop took place in Houston in February 1968 under our direction and extended the interchange to other professions allied to mental health--psychology, social work, education, rehabilitation, and the ministry. Particular care was taken to include deaf professionals, and representatives of government agencies provided guidelines for future programs. The proceedings of this conference for non-medical professionals were also published by the Department of Health, Education, and Welfare under the title, Mental Health and the Deaf, Approaches and Prospects, edited by K. Z. Altshuler and J. D. Rainer. Both volumes were distributed nationally and internationally to those concerned with the psychiatric and mental health problems in the rehabilitation of deaf persons.

In addition to these large conferences, members of the project staff participated in all major rehabilitation meetings scheduled and supported by such agencies as the Social and Rehabilitation Service, the Professional Rehabilitation Workers with the Adult Deaf, the Council of Organizations Serving the Deaf, and various state and

local agencies. Training programs were given to groups of ministers, to houseparents; an entire day was devoted by the staff to the International Conference on Rehabilitation of the Deaf, where experts in psychiatry, psychology, audiology, otology and other fields from the entire world both learned and participated. Equally significant was the training of 5 Gallaudet students who were exposed to the mental health problems of the deaf during summer work in our program under the direction of the project's social worker; participation in the clinical apprenticeship program of the New York University Center, a psychological trainee program with participants from a number of states; and visits by psychiatrists from various parts of the state who had come into contact with deaf patients in their local communities and were interested in learning what could be done.

REVIEW AND FORECAST

In describing the 3 year program of intensive exploration and work just completed, we have emphasized and documented its advances and achievements. We must also not fail to point to the stirrings and rumblings which began during the program and will continue into the future, to the increased awareness of the problems involved in a psychiatric program for the deaf, both in our own state and throughout the country and the world, and to the corresponding changes in attitudes and practice on the parts of community and rehabilitation agencies both state and private. In demonstrating how certain problems may be solved, we have also been able to delineate more clearly the tasks which still remain.

Under the category of achievement we have shown that an intensive, coordinated, longitudinal program with extensions into prevention and rehabilitation can benefit almost every deaf person who comes within its scope. The time, money and most important, human potential ultimately saved as the result of the kind of program that we have demonstrated alone makes it worthwhile. It is most gratifying to note that, as in the past, the new programs described in the present report have been made a permanent part of the services for the deaf under the New York State Department of Mental Hygiene.

But not only has our own New York State program been enriched by the extension beyond the walls of the hospital and clinic; the cooperating agencies themselves have found new paths to better achieve their own goals, whether they be education or rehabilitation. Schools for the deaf--both the one with which we worked and others with whom we have had innumerable contacts through individual visits, conferences, and discussions--have learned how to extend the scope of their

care for the emotional development of the deaf youngster under their enrollment. Our activities, writings, and discussions have helped to make these educational institutions aware of the important role of the parents who sometimes have been neglected, particularly in the residential school setups.

In the community, we have educated rehabilitation centers to understand the need for working together with mental health personnel rather than in some kind of competition or complete partition of their responsibilities. The fact that unusual patience is required in work with persons who have a double handicap of deafness and mental illness has been brought home to these agencies, and they are beginning to understand that a case should never be closed, that several trials may be required, and that ultimate success is attainable.

The halfway house with whom we worked found out not only that they could be helpful to the deaf patients and to our project, but that the presence of a nucleus of deaf patients was valuable to the hearing ex-patients under their care. The workers at Fountain House and the entire organization benefited from the stimulus of the special problems as well as the special opportunities for communication presented by the deaf.

In the course of our program other community groups were also stirred up. These included law enforcement agencies, so that we have been able to educate judges, lawyers and probation officers regarding the problems of responsibility, of capability, of rehabilitation of offenders, and elucidation of many medical-legal problems. Our contacts with the clergy at special training courses and at the Houston workshop have delineated their role in working with some of the family problems and the religious and moral issues for which they are sought by their deaf congregations.

When it comes to the gaps still remaining in service and in knowledge, a number of these have come clearly to our attention and should be noted as definite recommendations in considering the direction of future planning for the deaf.

The most pressing problem in the area of mental health care for the deaf is the area of prevention and treatment for the young deaf child and the school age youngster. In the area of prevention, we need earlier case finding when it comes to deafness and immediate conferences with parents to prevent the sense of hopelessness and guilt and instill in the parent the need and possibility for communication with the child at all levels. Even with improved programs, children will be found in schools who have mild, medium and severe behavior problems. Expanded psychiatric programs are needed with recruitment of child psychiatrists to the field and new approaches to family therapy. Some children will continue to be so disturbed in spite of treatment at the site (change of approach, medication, work with parents) that it would not be possible for them to remain in the ordinary classroom. For this an entirely new facility must be established--special classes or special schools for such students in a mental health unit where they may be transferred for as short a time as possible in order to attempt to treat them and make them ready for return to the normal classroom. Closeness to a psychiatric teaching unit would seem to be important, while establishment on the grounds of a school rather than a hospital would provide the best atmosphere.

Another untapped area is the problem of mental retardation in the deaf. Mental retardation may be due to a variety of causes some of which may include problems of deafness as well. Some persons may have multiple physical and neurological handicaps, others simply show an I Q deficit. Diagnosis, case finding, setting up

training centers, both on inpatient and outpatient basis, are called for, and then rehabilitation, finding work, finding a place for the less severely retarded deaf and the proper institutional setting for the very severely retarded deaf.

We believe we have demonstrated the need for and usefulness of properly organized rehabilitative and preventive services. With these now permanently established in New York State, we plan to move to further clinical programs for children and to new research projects of a psychologic and cross cultural nature and of a genetic and biochemical nature, and to do our best to stimulate activity throughout the nation by our example, our publications and lectures, and most importantly, by the success of our patients.

APPENDIX

Psychiatric Ward For The Deaf

PSYCHIATRIC WARD FOR THE DEAF

PATIENTS ON HOSPITAL BOOKS*, JANUARY 1966 AND THEREAFTER TO JULY 1, 1969

#	ID#	AGE	SEX	1ST ADM TO WARD	READM TO WARD	YRS HOSPLZN TO JULY 1, 1969	DIAGNOSIS ON WARD	INDEPENDENT PROGNOSIS**	RESULT AS OF JULY 1, 1969	COMMENT
ON ROLLS 1966										
1	419611	42	F.	4/5/63	--	23 yrs. w/2 yrs. out	Schizophrenia, Chronic Undifferentiated, w/ Mental Deficiency; Diabetic	Poor	Poor	On ward-reluctant to leave hospital
2	606744	36	F.	4/5/63	--	16 yrs. w/2 yrs. out	Schizophreniform Psychosis w/ Mental Deficiency; Diabetic	Poor	Poor	Transferred to other hospital
3	355139	72	F.	4/5/63	--	28 yrs. w/1 yr. out	Involutional Psychosis, probably with superimposed Chronic Brain Syndrome	Poor	Guarded	Discharged to cnty. home
4	562866	45	F.	4/5/63	1	5 adms. each about 1 yr.	Schizophrenia, Chronic Paranoid	Guarded	Fair	Discharged-homemaking
5	725865	40	F.	4/15/63	2	10 yrs.	Schizophrenic, Chronic Undifferentiated	Poor	Fair	Discharged-working
6	500129	40	F.	4/17/63	1	10 adms. from 1947-1967	Schizophrenia, Chronic Undifferentiated	Poor	Guarded	Discharged-working

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#	ID#	AGE	SEX	1ST ADM TO WARD	READM TO WARD	YRS HOSPLZN TO JULY 1, 1969	DIAGNOSIS ON WARD	INDEPENDENT PROGNOSIS**	RESULT AS OF JULY 1, 1969	COMMENT
7	927021	28	F.	4/17/63	--	5 yrs. hosp. 1962-1967	Adult Situational Reaction (Primitive Personality)	Poor	Fair	Discharged-working
8	524452	42	F.	4/17/63	--	22 yrs. hosp. out 6 mos.	Schizophrenic, Chronic Catatonic	Poor	Poor	Transferred to other hospital
9	951495	42	F.	12/4/63	1	2 yrs. hosp.	Schizophrenia, Acute Paranoid	Guarded	Fair	Discharged-working
10	664273	26	M.	1/8/64	--	11 yrs. hosp.	Schizophrenia, Chronic Undifferentiated	Poor	Fair	Discharged-working
11	787738	27	M.	1/8/64	--	8 yrs. with Deterioration	Schizophrenia, Chronic Undifferentiated	Poor	Poor	On ward
12	685743	34	M.	1/21/64	--	14 yrs. hosp.	Schizophrenia, Chronic Undifferentiated	Poor	Poor	On ward
13	947610	23	F.	1/27/64	--	6 yrs. hosp.	Adult Situational Reaction (Primitive Personality)	Poor	Fair	Discharged-working
14	968099	21	F.	3/20/64	2	8 yrs. hosp.	Chronic Brain Syndrome w/ Behavioral Reaction	Poor	Guarded	On ward

#	ID#	AGE	SEX	1ST ADM TO WARD	READM TO WARD	YRS HOSPLZN TO JULY 1, 1969	DIAGNOSIS ON WARD	INDEPENDENT PROGNOSIS**	RESULT AS OF JULY 1, 1969	COMMENT
15	968190	48	F.	4/9/64	1	2 yrs. hosp. 2 yrs. out	Schizophrenia, Chronic, Paranoid	Guarded	Fair	Discharged-working
16	420691	48	M.	4/20/64	--	23 yrs. hosp.	Schizophrenia, Chronic, Paranoid	Poor	Fair	Discharged-cnty. home
17	772153	56	M.	4/29/64	--	8 yrs. hosp.	Schizophrenia, Chronic Simple	Poor	Poor	On ward
18	772788	32	F.	6/2/64	1	13 yrs. hosp.	Schizophrenia, Chronic Undifferentiated, Retinitis Pigmentosa (Progressive Visual Loss)	Poor	Poor	Discharged-working in sheltered work shop
19	971255	31	F.	6/17/64	2	2 yrs. hosp. 2 yrs. out	Schizophrenia, Chronic, Mixed Type	Guarded	Fair	Discharged-homemaking
20	952204	24	F.	8/21/64	--	1 yr. hosp.	Adult Situational Reaction	Poor	Fair	Discharged-homemaking
21	764327	30	M.	10/13/64	1	3 yrs. hosp. 1 yr. out	Schizophrenia, Chronic, Paranoid	Poor	Guarded	Discharged-working
22	686388	22	M.	11/6/64	1	11 yrs. hosp.	Primary Behavior Disorder, Conduct Disturbance	Poor	Good	Discharged-training

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23	747432	27	F.	11/30/64	1	8 yrs. hosp. 1 yr. out	Schizophrenia, Chronic, Paranoid	Poor	Guarded	Transferred to other hospital
24	988101	63	F.	12/11/64	--	1 yr. hosp. 2 yrs. out	Depressive reaction in an Inadequate Personality	Guarded	Good	Discharged-homemaking
25	988264	38	F.	1/21/65	--	1 yr. hosp. 1 yr. out	Schizophrenia, Acute Paranoid	Guarded	Good	Discharged-homemaking
26	988406	23	M.	2/24/65	--	1 1/2 yrs. hosp. 1/2 yr. out	Personality Trait Disturbance	Guarded	Fair	Discharged-not working
27	968610	20	F.	3/9/65	--	1 yr. hosp. 2 yrs. out	Primary Behavior Dis., Retinitis Pigmentosa (Progressive Visual Loss)	Guarded	Good	Discharged-training
28	901417	28	M.	3/23/65	--	6 yrs. hosp. 1 yr. out	Schizophrenia, Chronic Undifferentiated	Poor	Fair	Discharged-not working
29	453396	45	F.	6/23/65	--	7 yrs. hosp. 13 out	Schizophrenia, Chronic, Catatonic	Poor	Guarded	Discharged-homemaking
30	908656	30	M.	7/18/65	--	4 yrs. hosp. 1 yr. out	Schizophrenia, Chronic Paranoid	Poor	Fair	Discharged-not working

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31	780369	31	F.	7/7/65	--	9 yrs. hosp.	Schizophrenia, Chronic, Paranoid	Poor	Poor	Transferred to other hospital
32	1000404	62	M.	7/9/65	--	3 mos. hosp.	Acute Brain Syndrome	Fair	Good	Discharged-working
33	998229	19	M.	9/16/65	1	2 yrs. hosp.	Primary Behavior Disorder	Fair	Good	Discharged-training
34	724571	43	M.	8/20/65	--	7 yrs. hosp.	Schizophrenia, Chronic Paranoid	Poor	Good	Discharged-working
35	1000565	42	F.	8/23/65	--	3 yrs. hosp.	Schizophrenia, Chronic, Undifferentiated	Poor	Good	On ward
36	749523	19	M.	9/3/65	--	10 yrs. hosp.	Personality Trait Disturbance, Dissocial Reaction	Poor	Guarded	Discharged-working
37	376688	43	M.	9/22/65	--	25 yrs. hosp.	Passive Aggressive Personality, Passive Dependent Type	Guarded	Fair	Discharged-working
38	741503	25	M.	9/22/65	--	8 yrs. hosp.	Personality Trait Disturbance, Dissocial Reaction	Guarded	Fair	Discharged-working

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39	920661		M.	9/22/65	--	5 yrs. hosp.	Inadequate Personality	Poor	Poor	Transferred to original hospital
40	490296	57	F.	10/15/65	--	20 yrs. hosp.	Inadequate Personality	Poor	Fair	Discharged-cnty. home
41	622178	25	F.	10/15/65	--	15 yrs. hosp.	Schizophrenia, Chronic Undifferentiated w/ Organic Features	Poor	Poor	Transferred to original hospital
42	1000891	23	F.	11/24/65	--	2 yrs. hosp.	Schizophrenia, Chronic, Mixed	Poor	Fair	Discharged-homemaking
43	994546	23	F.	12/13/65	--	4 yrs. hosp.	Dissociative Reaction	Poor	Poor	Transferred to original hospital
Admitted during 1966										
44	491017	41	M.	4/25/66	--	19 yrs. hosp.	Schizophrenia, Chronic, Undifferentiated	Poor	Fair	Discharged-training
45	1022806	30	M.	5/24/66	--	1 month hosp.	Schizophrenia, Chronic, Undifferentiated	Poor	Poor	Discharged-not working
46	1022832	31	F.	6/1/66	--	1 month hosp.	Passive Aggressive Personality w/ Depressive Reaction	Fair	Good	Discharged-homemaking

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47	1022987	52	F.	7/5/66	--	3 short hosplzns between 3-5 mos.	Schizophrenia, Chronic, Paranoid	Fair	Good	Discharged-working
48	682453	40	M.	8/1/66	--	7 yrs. hosp. 6 yrs. out	Schizophrenia, Chronic, Paranoid	Poor	Poor	Transferred to other hospital
49	674654	28	M.	8/11/66	--	13 yrs. hosp.	Schizophrenia, Chronic, Mixed	Poor	Poor	On ward
50	1023188	42	F.	8/24/66	--	2 mos. hosp.	Psychoneurosis, Reactive Depression	Good	Good	Discharged-homemaking
51	1023383	48	F.	10/18/66	--	1 yr. hosp.	Schizophrenia, Acute, Paranoid	Fair	Fair	Discharged-homemaking
52	1023427	42	F.	10/27/66	--	3 mos. hosp.	Schizophrenia Reaction, Acute, Undifferentiated	Fair	Fair	Discharged-homemaking
53	721080	52	M.	11/1/66	--	7 yrs. hosp.	Schizophrenia, Chronic, Simple	Poor	Fair	On ward
54	838531	42	M.	11/1/66	--	13 yrs. hosp.	Schizophrenia, Chronic, Undifferentiated, Retinitis Pigmentosa (Progressive Visual Loss)	Poor	Fair	Discharged-training

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55	838660	42	M.	12/21/66	--	26 yrs. state sch.	Behavior Disorder, Mental Deficiency	Poor	Guarded	Discharged-working
56	893805	22	M.	12/30/66	--	3 yrs. hosp.	Inadequate Personality	Fair	Fair	Discharged-training
Admitted during 1967										
57	580862	50	F.	1/24/67	--	18 yrs. hosp.	Schizophrenia, Chronic Undifferentiated. Retinitis Pigmentosa (Progressive Loss of Vision)	Poor	Poor	On ward
58	1047293	27	F.	1/24/67	--	3-4 mos.	Schizophrenia, Chronic Undifferentiated. Retinitis Pigmentosa (Progressive Visual Loss)	Fair	Fair	Discharged-working
59	300534	40	M.	2/2/67	--	22 yrs. hosp.	Schizophrenia, Chronic Undifferentiated. Retinitis Pigmentosa, Blind	Poor	Poor	Transferred to other hospital
60	646193	23	M.	2/28/67	--	15 yrs. hosp.	Psychosis w/Other Infect. Disease, Status after Meningitis	Poor	Guarded	Discharged-job/training

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61	927131	20	F.	3/9/67	--	6 yrs. hosp.	Personality Trait Disturbance: Passive Aggressive Type	Guarded	Guarded	Discharged-homemaking
62	1047603	19	M.	4/8/67	--	2 yrs. hosp.	Schizophrenia, Chronic Undifferentiated	Poor	Poor	Discharged-not working
63	1047802	43	F.	5/26/67	--	5 mos. hosp.	Involutional Psychosis	Guarded	Fair	Discharged-working
64	1048012	29	F.	6/19/67	--	1 month hosp.	Schizophrenia, Acute, Mixed	Fair	Fair	Discharged-working
65	1070501	18	M.	7/6/67	--	1 month hosp.	Inadequate Personality & Retinitis Pigmentosa	Poor	Fair	Discharged-school
66	951890	25	M.	8/8/67	--	6 yrs. hosp.	Inadequate Personality	Guarded	Fair	Discharged-not working
67	1070986	19	M.	10/30/67	--	3 yrs. hosp.	Schizophrenic, Chronic Childhood Type	Poor	Poor	On ward
68	1071031	66	F.	11/20/67	--	3 yrs. hosp.	Chronic Brain Syndrome w/ Depressive Features	Poor	Guarded	On ward

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69	1071109	23	F.	11/28/67	--	1 yr. hosp.	Psychoneurosis, Obsessional Neurosis	Fair	Good	Discharged-in training
70	1071110	33	M.	11/29/67	--	1 yr. hosp.	Inadequate Personality	Guarded	Fair	Discharged-not working
71	1071174	16	M.	12/11/67	--	1 yr. hosp.	Schizophrenia, Childhood Type	Guarded	Guarded	Discharged-training
72	858203	22	M.	12/14/67	--	16 yrs. state school	Mental Deficiency with Behavior Disorder	Poor	Guarded	Discharged-working
73	674654	16	M.	11/14/67	--	7 yrs. hosp.	Primary Behavior Disorder	Guarded	Fair	On ward
74	895783	17	M.	11/14/67	--	4 yrs. hosp.	Prim. Behav. Disorder, Conduct Disturbance	Poor	Fair	On ward
75	858203	23	M.	12/14/67	--	17 yrs. state school & hsp.	Borderline Mental Retardation w/ Deafness	Fair	Good	Discharged-working
Admitted during 1968										
76	1048581	76	M.	1/24/68	--	2 yrs. hosp.	Psychosis with Cerebral Arteriosclerosis	Poor	Poor	Transferred to another ward

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77	1071347	29	F.	1/18/68	1	5 mos. hosp.	Psychoneurosis Mixed Type	Fair	Good	Discharged-homemaking
78	846031	26	F.	2/29/68	--	3 mos. hosp.	Psychosis w/ Mental Deficiency	Fair	Good	Discharged-working
79	1089570	18	M.	7/30/68	--	16 mos. hosp.	Dissocial Behavior	Fair	Guarded	Discharged-training
80	1093393	18	F.	7/31/68	1	1 yr. hosp.	Behav. Disorder of Adolescence. Unsocialized Aggr. Reaction of Adoles.	Fair	Guarded	On ward
81	1093462	48	F.	8/28/68	--	31 yrs. hosp.	Depressive Neurosis	Fair	Good	Discharged-working
82	1093644	20	F.	10/23/68	--	1 yr. hosp.	Schizophrenia Catatonic	Fair	Good	On ward
83	1093656	20	M.	10/28/68	--	1 month hosp.	Adjustment Reaction of Adult Life	Fair	Fair	Discharged-working
84	1088301	26	F.	11/20/68	--	1- 1/2 yr hosp.	Explosive Personality	Fair	Guarded	On ward
85	1045574	39	F.	12/1/68	--	3 mos. hosp.	Explosive Personality	Fair	Fair	Discharged-homemaking

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86	1097209	19	F.	12/6/68	--	1 yr. hosp.	Psychosis w/ Mental Deficiency	Fair	Guarded	On ward
Admitted during 1969 (to July 1)										
87	961513	15	M.	3/12/69	--	6 yrs. hosp.	Behav. Disorder Assoc. w/ Somatic Defect or Disease	Fair	Poor	On ward
88	1112701	24	M.	6/5/69	1	1 month hosp.	Moderate Mental Retardation	Fair	Guarded	On ward
89	1112502	23	F.	3/10/69	--	2 mos. hosp.	Depressive Neurosis	Fair	Good	Discharged-homemaking
90	1085498	16	F.	3/19/69	--	3 mos. hosp.	Schizophrenia Childhood Type	Fair	Fair	On ward
91	947824	42	M.	4/16/69	--	6 yrs. hosp.	Schizophrenia Paranoid Type	Fair	Fair	Discharged-working
92	689169	33	M.	5/1/69	--	12 yrs. hosp.	Schizophrenia Paranoid Type	Poor	Fair	On ward
93	1112835	38	F.	6/18/69	--	6 yrs. hosp.	Schizophrenia Paranoid Type	Fair	Guarded	On ward
94	1112948	15	M.	7/29/69	--	1 yr. hosp.	Adjustment Reaction of Adolescence	Fair	Fair	On ward

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95	1112954	18	F.	7/30/69	--	4 mos. hosp.	Acute Schizophrenic Episode	Poor	Fair	On ward
96	1112986	16	F.	8/18/69	--	3 mos. hosp.	Adjustment Reaction of Adolescence	Fair	Guarded	On ward

* On books includes patients on convalescent care (out of hospital but not yet officially discharged).

** Prognosis and result according to the following:

poor: patient will probably remain chronically hospitalized for life.

guarded: no real improvement expected, may be out of the hospital briefly, but will probably be in the hospital more than out for the balance of his life.

fair: some improvement expected, probably will be out of the hospital more than in, although exacerbations of illness are expected.

good: chance of permanent rehabilitation with no or occasional brief returns to the hospital.

BIBLIOGRAPHICAL NOTE

The New York State program for the deaf has been responsible for four volumes published during the years 1963-1969. These volumes are:

Family and Mental Health Problems in a Deaf Population, edited by J.D. Rainer, K.Z. Altshuler and F.J. Kallmann with the assistance of W.E. Deming. Originally published in 1963 by the Department of Medical Genetics, New York State Psychiatric Institute, it was re-issued in a second edition in 1969 by Charles C Thomas, Inc., Springfield, Illinois from whom it is presently available.

Comprehensive Mental Health Services for the Deaf, by J.D. Rainer and K.Z. Altshuler. Published in 1966 by the Department of Medical Genetics, New York State Psychiatric Institute.

Psychiatry and the Deaf, edited by J.D. Rainer and K.Z. Altshuler. Published in 1968 by the Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare. (Proceedings of Workshop for Psychiatrists, New York, April 1967).

Mental Health and the Deaf: Approaches and Prospects, edited by K.Z. Altshuler and J.D. Rainer. Published in 1969 by the Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare. (Proceedings of National Conference on Mental Health Services for Deaf People, Houston, February 1968). This book and the preceding two are available from the New York State Psychiatric Institute, 722 West 168th Street, New York 10032.